S. HRG. 100-288

SAFETY AND SOUNDNESS STANDARDS IN THE MAIL ORDER PRESCRIPTION INDUSTRY

HEARINGS

BEFORE THE

SUBCOMMITTEE ON GOVERNMENT EFFICIENCY, FEDERALISM, AND THE DISTRICT OF COLUMBIA

OF THE

COMMITTEE ON GOVERNMENTAL AFFAIRS
UNITED STATES SENATE

ONE HUNDREDTH CONGRESS

FIRST SESSION

AUGUST 5, 6, 1987

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SAFETY AND SOUNDNESS STANDARDS IN THE MAIL ORDER PRESCRIPTION INDUSTRY

WEDNESDAY, AUGUST 5, 1987

U.S. Senate,
Subcommittee on Government Efficiency,
Federalism, and the District of Columbia,
Committee on Governmental Affairs,
Washington, DC.

The Subcommittee met, pursuant to notice, at 1:50 p.m., in room SD-342, Dirksen Senate Office Building, Hon. Jim Sasser (Chairman of the Subcommittee) presiding.

Present: Senators Sasser and Heinz.

OPENING STATEMENT OF SENATOR SASSER

Senator **Sasser**. Good afternoon. The Subcommittee on Government Efficiency, Federalism, and the District of Columbia will come to order.

I apologize for being tardy in calling the Subcommittee into session today. We had a rather important meeting with the majority leader and others relevant to the new proposal on the part of the administration for dealing with the problems in Central America and with the Sandinista Government in Nicaragua. So that is the reason for my tardiness.

Today we begin 2 days of hearings into a matter of crucial importance to all Americans: the safety and soundness standards employed in dispensing mail order drugs.

Now, let's be clear on what we are discussing here today. Prescription drugs are big business, both for the retail druggist and the mail service pharmacy. About $21 billion a year are spent on prescription drugs, and millions of Americans rely daily on a wide variety of medications and, at least right now, they take those medications with a large degree of confidence, I am glad to say.

That confidence is the result of a system that has been built around a high degree of care, skill and dedication; the same care, skill and dedication that we demand from our pharmaceutical companies and from the pharmaceutical community, in general.

Not too many years ago, the method for dispensing prescription drugs was the same all across the country. You simply went into your local drugstore, presented a prescription that had been written by your physician, and you got the proper medication from your local pharmacist. And you could, in those days, be virtually certain that the drug you ultimately took would be the drug named in the prescription you received. And you could be sure of that whether you were in Ohio or Utah or in my native State of Tennessee.

But today the circumstances have changed in the drug dispensing industry, just as they have in so many other industries across the country. With computers, automation, and the radical growth of different kinds of prescription medicines, all of these factors have revolutionized the pharmaceutical practices in this country.

One of the fastest growing parts of this revolution in the pharmaceutical community is the mail order drug business. Presently, mail order prescriptions make up about 4 percent of a $21 billion market. By 1991 mail order prescription drugs will compose, according to one recent industry analysis, about 10 percent of a $28 billion business. So there is rapid and substantial growth predicted for the mail order drug business.

Today, someone with a health problem can receive a prescription drug from a wide range of mail order outlets, from a Government agency like the Veterans' Administration, from a nonprofit company, such as the mail order business operated by the American Association of Retired People, or from a variety of for-profit firms, including companies that deal exclusively in the mail order drug business.

When a doctor in Wyoming or Utah or Arkansas fills out a prescription and gives it to a patient, it can just as easily be filled in New Jersey as in the patient's local pharmacy around the block or down the street or down the road. In other words, the distance between the patient and the pharmacist that fills the prescription is stretching out and direct contact between the two is becoming more and more a thing of the past.

As testimony today and tomorrow will confirm, very powerful market forces are turning the mail order drug business into a growth industry. We see that businesses and unions concerned about the explosion of medical costs, and also cost conscious consumers are trying to buy their prescription drugs just as cheaply as possible, and this has created a great market opportunity, particularly for mail order drug firms.

The new industry is taking advantage of this opportunity by adopting modern distribution techniques. Doing this in response to consumer demand, this provides for accessible and cheaper drugs. All of that, of course, is precisely as it should be.

This hearing is not designed in any way to impede the development of a new industry. Quite the reverse. We are here today to inquire into the safety and soundness standards that are being followed by mail service pharmacies, particularly those that are being promoted directly as a result of Federal policy.

Our aim today is to ensure that those safety and quality assurance practices in the mail order drug business are sufficiently high to guarantee public confidence, for only where that kind of confidence exists can a new industry expect to thrive and can expect reasonably to grow.

Now, testimony offered here today will suggest that there is reason to believe that safety and soundness standards are not all that they should be in the mail order drug business, or at least in some facets of it. We will hear from a consumer from Virginia Beach who received a 90-day supply of a drug called Coumadin—a blood thinner—rather than Corgard, which her doctor had prescribed for her, which is a beta blocker for use in lowering hypertension.

If she had taken the blood thinner, Coumadin, sent to her by mistake, her life might very well have been endangered.

Another Virginia consumer received, through a mail order pharmacy, a drug called Feldene, which is an anti-inflammatory pain killer, and he received this drug rather than a drug called Procardia, which he was to take for a heart condition. It is a calcium blocker. He subsequently developed a gastric ulcer, was hospitalized and later expired.

In another case, a Michigan consumer ordered Valium by mail for treatment of hypertension as prescribed by her physician but received instead a drug called Novadex, an anti-cancer drug which can create very serious side effects.

Now obviously, this is anecdotal evidence and, obviously, these are three incidents that have occurred in the literally millions of prescription that have been filled. But we have no way of knowing right now how widespread these errors may be or how serious the problem has become.

We will try to get some idea from the testimony of pharmacists who formerly worked for a major mail service pharmacy. They will express their grave reservations about the quality control procedures employed in the dispensing of mail order drugs. In the same vein, a number of retail pharmacists, both in their individual capacity as drugstore operators, and also as representatives of the National Association of Retail Druggists, will testify as to their doubts about the safeguards employed by so-called mail order pharmacies.

Finally, we will be hearing today from representatives of the mail order operations themselves. We will be attempting to establish the foundation for assessments of the risks that are potentially posed by the mail order drug industry, what the industry itself is doing to mitigate these risks, and what the Federal Government needs to do, if anything, to assure the highest possible standards of safety.

Now, I strongly believe that the Federal Government, in so far as it directly or indirectly promotes the concept of mail order pharmacies, has an obligation to the consumer. And I can think of few areas where that obligation is stronger. We should be able to make certain fundamental guarantees to those who consume medications in this country.

These fundamental guarantees should be that they should not receive drugs that are intended for other persons. They should not receive drugs that are outdated. They should not receive drugs that, if taken by mistake, can cause adverse reactions. They should not receive an incorrect prescription. They should not receive an incorrect dosage.

That basic pharmaceutical bill of rights should be the minimum, I think, that we seek to achieve. Anything less than the lowest possible margin of error is a travesty of this Nation's health care system and poses a grave risk to many of our citizens. Now, it is my hope that this hearing will take the first steps toward reaffirming the confidence of America's pharmaceutical consumers.

Our first panel of witnesses today will be Mrs. Winifred Owens and Mr. Keith Kellum. Mrs. Owens is a resident of Virginia Beach, VA, and Mr. Kellum is a registered pharmacist from Virginia Beach, VA.

Would those two witnesses please come forward.

Mrs. Owens, I would like to welcome you here today. I understand you are accompanied by your husband, Mr. Berton Owens. We welcome you also, Mr. Owens. And Mr. Kellum, we are delighted that you could make this journey today.

Mrs. Owens, if you have a statement, we would be delighted to receive that statement and after that I will have some questions. Also, we would like to hear, perhaps, from Mr. Kellum. I understand that you will be offering, Mr. Kellum, a prepared statement of Mr. Ted Cash, a registered pharmacist from Virginia Beach, VA.[1]

Mrs. Owens, we will begin with you.

TESTIMONY OF WINIFRED OWENS, VIRGINIA BEACH, VA; AND KEITH D. KELLUM, R.PH., VIRGINIA BEACH, VA [2]

Mrs. OWENS. In January of this year I found myself placed at great risk by poor quality control in mail order prescription service which had just been available to us. As a wife of a retired civil service employee, I am covered under the civil service benefit plan, Blue Cross/Blue Shield of the Federal Employees Health Benefit Program.

I have controlled hypertension for years using oral medication. My husband has also been on oral medication for diabetes for a number of years. The promise of a 90-day supply of each of our prescriptions for $5 per prescription sounded very good. Three of our prescriptions were filled accurately with the medications prescribed or their generic equivalent.

The fourth, which was supposed to have been Corgard, my primary hypertension medication, did not look right. Instead of a bright blue tablet about the diameter of your little finger, I was sent a small pink tablet about the size of a pencil. I called Ted Cash, who had been filling our prescriptions for years, and asked if anyone made a Corgard equivalent in that size and color. He urged me to bring them down and promptly identified the pills as Coumadin, which is a very powerful blood thinner used to prevent clotting of the blood.

Mr. Cash was much relieved to find that I had not taken any of the Coumadin. He advised me that if I had taken them on the schedule of one a day as prescribed for my Corgard, I would have been in danger of uncontrollable bleeding from a simple kitchen cut, and I have the bottle here with the pills in it.

Mr. Cash furnished manufacturers data about Coumadin. Its chemical name is Crystalline Warfarin Sodium. It is related to the Warfarin which is so effective as a rat poison. It is simply advised against for use in patients having hypertension.

The label pasted on the bottle stated that the contents were 80 milligrams Corgard, and the doctor's instructions were properly shown. However, if you hold the bottle to the light, you are able to see the Crystalline Warfarin Sodium name label attached by the manufacturer. If it had been my first prescription for Corgard or if my eyesight were poor, I would have been in great danger.

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[1] See p. 248.

[2] See p. 89 for Mr. Kellum's prepared statement.

My husband and I were outraged at this kind of callousness and we wrote a strong letter to National Rx Services in Florida. Copies were sent to the pharmaceutical control agencies in Virginia and Florida. For good measure, we sent copies to the Office of Personnel Management, which is supposed to administer the Federal Employees Health Benefits Program, and to our Congressman, the Honorable Owen Pickett.

We really did not ask him to help directly. We wished only to inform. As it worked out, I doubt we would have heard anything at all if his inquiries had not stirred up a response. The Virginia Board sent us a copy of the letter they addressed to the Florida Board telling them that it was their "hot potato." On April 27th Mr. Pickett forwarded a copy of the OPM response to him in which they promised to write again after they received a full report from their FEHB manager.

As of the 5th of August we have heard nothing more and the OPM never did respond to our direct inquiry to them. We did receive an apologetic letter dated May 6th from Medco Containment Services, Inc., saying they were the parent company of National Rx Services, Inc. The executive vice president, operations, assured us that the National was very distressed and had already taken corrective actions which had been approved by the Florida Board of Pharmacy.

This letter fails to comfort us, since it also states:

> It should be noted that as a result of our previous correspondence, National Rx Services, Inc., initiated an immediate and thorough investigation of the facts of which you complained and promptly provided you with your medication.

It should be noted that it was so thorough that they never contacted us nor did they send the medication. The OPM did forward Congressman Pickett a copy of the Medco letter which we had received a month earlier.

I do appreciate that I have the opportunity to relate my story to this Senate group. I hope you will find a way to insure that some of the cost savings of large scale mail order prescription service can be maintained while setting up enough interstate controls that it will be safe. Since the incident in January my husband's health needs have added another $65 per month to the cost of prescriptions he will have to take. As part of the continuing rise in health care costs this is frightening. It is important that the concept of mail order service be preserved but we would rather pay $7 to $10 per prescription if that is what is needed to insure adequate quality control. In actuality we suspect the profit margin is sufficient to permit adequate quality control without passing the cost back to us.

Senator **SASSER**. Well, thank you, Mrs. Owens. Now, let me see if I fully understand your testimony here today. You are telling this Subcommittee that you suffer from hypertension; is that correct?

Mrs. **OWENS**. Yes, sir.

Senator SASSER. And that your physician or doctor had prescribed a medication to relieve or to treat the hypertension?

Mrs. OWENS. Control it, yes, sir.

Senator SASSER. To control the hypertension. You had originally, I suppose, purchased your medication from a local pharmacist?

Mrs. OWENS. From Giant Pharmacy.

Senator SASSER. Right.

Mrs. OWENS. And I knew both pharmacists personally, on a first-name basis.

Senator SASSER. So you knew what this particular medication looked like?

Mrs. OWENS. Yes, because I had been taking it for years.

Senator SASSER. Then I suppose you sent off to request the medication from the mail order drug firm?

Mrs. OWENS. Yes, in January.

Senator SASSER. Did you have to enclose a prescription with that order?

Mrs. OWENS. Yes, a 90-day prescription from my doctor.

Senator SASSER. And he wrote you a prescription——

Mrs. OWENS. For 90 days.

Senator SASSER [continuing]. For the anti-hypertensive drug?

Mrs. OWENS. Yes.

Senator SASSER. Then when you received the medication back through the mail, how long did you have to wait for the medication?

Mrs. OWENS. About 6 weeks.

Senator SASSER. About 6 weeks.

Mrs. OWENS. Because we were getting ready to go out of town on a business trip.

Senator SASSER. And when the medication came back through the mail you opened it up and examined it; is that correct?

Mrs. OWENS. That is right, and the other three were all right, but this one was not.

Senator SASSER. Now, you had four bottles of medicine?

Mrs. OWENS. Yes.

Senator SASSER. And three of them you recognized as the proper anti-hypertensive drug?

Mrs. OWENS. No. Some were my husband's drugs.

Senator SASSER. Your husband's medication was correct?

Mrs. OWENS. Yes.

Senator SASSER. But then when you examined your drug you realized that this did not look like the drug that you had taken heretofore?

Mrs. OWENS. That is right.

Senator SASSER. What did you do with that drug?

Mrs. OWENS. Well, I called Ted. He happened to be on that evening and I asked him if anybody had come out with a generic Corgard and he said no. He said, why? I told him and he said, would you bring the pill down here, the bottle down. I did, and he took one look at it and he says, it is written right on the pill. He says, it is Coumadin.

Senator SASSER. Now, who was this that you took it to?

Mrs. OWENS. Ted Cash, my druggist. My local druggist.

Senator **Sasser**. And he is the one that identified the drug that you had received by mail as Coumadin?

Mrs. **Owens**. Yes, and he gave the two of us a piece of paper that came out of the bottle that he had on the shelf showing the dangers. You are not supposed to take it if you have hypertension, this Coumadin that they sent me.

Nothing came except the label Corgard on the outside.

Senator **Sasser**. Now, the bottle—may I see that bottle?

Now, this is the bottle your medication came in; is that correct?

Mrs. **Owens**. Yes. If you look under there you can see the——

Senator **Sasser**. Right. It is labeled National Drug Services and there is a label on it that says:

> Corgard Tabs, 80 milligrams.

But underneath that label, there is another label. What does that label say?

Mrs. **Owens**. Crystalline Warfarin Sodium.

Senator **Sasser**. And that is the generic drug name for Coumadin; is that correct?

Mrs. **Owens**. Yes. Mr. Kellum said it is.

Senator **Sasser**. So apparently they had simply taken a bottle that had the Coumadin in it and I assume by mistake had put a Corgard label over it.

Mrs. **Owens**. That is right.

Senator **Sasser**. Now, what did your hypertensive pills look like?

Mrs. **Owens**. Your staff member, Mr. Amitay, has a sample.

Senator **Sasser**. Would you describe them for us?

Mrs. **Owens**. They are a bigger blue pill.

Senator **Sasser**. And this is a small pink pill. So the small pink pill is the Coumadin and the large blue pill——

Mrs. **Owens**. Is the Corgard.

Senator **Sasser** [continuing]. Would be one that was prescribed by your doctor for your hypertension problem.

Well, there is certainly a distinct difference between the two medications.

Why do not we hear now from you, Mr. Kellum.

Mr. **Kellum**. Thank you, Mr. Chairman.

My name is Keith Kellum. I am a practicing pharmacist in Virginia Beach, Virginia. I practice at Bayside Pharmacy, which is an independent pharmacy in that neighborhood.

I have been asked to read a letter to the Subcommittee from Mr. Theron C. Cash III, who is Mrs. Owens' personal pharmacist and has been serving her interest and her needs in the past years that they have traded with Giant Pharmacy.

Senator **Sasser**. And you are a pharmacist yourself, Mr. Kellum?

Mr. **Kellum**. Yes, sir, that is correct. I am licensed to practice pharmacy in Virginia and in Texas.

The statement reads:

> Senate Subcommittee on Government Efficiency, Statement of Record, Wednesday, August 5, 1987.
>
> To whom it may concern: I am a registered pharmacist currently employed at Giant Pharmacy, 2868 Virginia Beach Boulevard, Virginia Beach, Virginia.
>
> On or about January 1, 1987, I was approached by Mrs. Winifred Owens concerning a prescription she had received from National Prescription Services in Tampa, Florida. Both Mr. Bert Owens and Mrs. Winifred Owens were regular customers at

the pharmacy for the 4 years I have been there. Mrs. Owens had sent her prescription for Corgard 80 mg to the National Prescription Service in Florida due to the fact that her husband's Blue Cross/Blue Shield Policy under the Federal Employees Health Benefit Program allowed her to receive a 90 days supply of medication for a small co-payment.

Mrs. Owens and her husband presented to me the prescription she received in the mail, expressing concern because the medication she received was a small pink tablet. Since Mrs. Owens had been taking Corgard 80 mg for hypertension for an extended period of time, she was familiar with the appearance of the Corgard as a large light blue tablet. The discrepancy in appearance led Mrs. Owens to question the drug she had received, wondering if it was a generic for Corgard or another drug.

I informed Mrs. Owens there was not a generic substitute for Corgard available, and upon examining the medication I was surprised to see she had gotten Coumadin, an anti-coagulant, 5 mg tablet and an amount of 90 tablets. The medication was clearly marked Coumadin, since the tablet was imprinted with the Coumadin 5 mg on one side of the tablet and DuPont imprinted on the other side of the tablet.

The bottle containing Coumadin was labeled Corgard 80 mg #90, with the direction to take one tablet daily. Also, clearly legible under the prescription label was a prepack label which stated Crystalline Warfarin Sodium. Mrs. Owens asked me what would have happened if she had taken this medication, and without going into specifics, I informed her that it could have been life threatening.

Having been a pharmacist for 10 years, I am aware that under stressful conditions and situations mistakes can be made in filling prescriptions, and any pharmacist who says he or she has not filled a prescription incorrectly is lying. On the other hand, certain medications automatically bring to mind the inherent possibilities of injury if the incorrect medication is dispensed, so that extra care should be used, as in this case.

I am sure that in these mail order operations that an assembly line type dispensing procedure is used and usually the prescriptions are filled by technicians and the pharmacists check the medication and directions for use but still there must be some control procedures in these operations. In this particular incident, a negligence suit could have easily occurred.

Mrs. Owens' response, when I informed her that she had received the wrong medication was one of shock and horror. Having explained to her that Coumadin was an anticoagulant which inhibited the normal process of blood clotting, she wondered what if she had been given a new medication she was not familiar with its appearance and had taken it or what if she, like many other individuals, just taken the medication they receive without regard to appearance, or if an elderly person with eye problems could not distinguish the appearance and the differences in medication, that the severity of this error would have been magnified.

Mrs. Owens informed me that from now on she would get her medications at my pharmacy rather than trust an unknown pharmacist in Florida, no matter what her Blue Cross/Blue Shield policy recommended or required. Mrs. Owens asked what actions she could take concerning this matter. I advised her to correspond this problem to the National Prescription Services, the Virginia Board of Pharmacy and Florida Board of Pharmacy, and Blue Cross/Blue Shield. On February 25, 1987 Mrs. Owens showed me a copy of the letter she was sending to the above-mentioned parties concerning this matter. Also, she said she sent a copy to our Congressional Representative, the Honorable Owen Pickett.

Mrs. Owens later brought to me the letter she received from Congressman Pickett, received in March 5, 1987. He stated receipt of her letter and his assistance in this matter by contacting officials of the Office of Personnel Management, which has jurisdiction over Federal Employees Health and Benefit Program. She also received a letter on March 15, 1987 from the Virginia Department of Health Regulatory Board stating receipt of complaint filed with the Board of Pharmacy of Virginia and that the matter did not fall within the Board's jurisdiction, but the complaint was forwarded by the Board of Pharmacy of Virginia to the Board of Pharmacy in Florida.

Mrs. Owens later received letters from the Board of Pharmacy of Florida and the National Prescription Services, stating the problem was being taken care of. To the best of my knowledge she did not receive any later correspondence on the matter until she and I were contacted by the Senate Subcommittee representatives.

Without going into great detail, Coumadin interferes with the synthesis of Vitamin K, a dependent clotting factor, thus depleting the body of certain clotting factors. In the case of Mrs. Owens, two problems would occur. Her blood pressure would increase due to her lack of Corgard, and taking Coumadin in its place would greatly diminish her bodies normal blood clotting capacity, where the principle adverse effect would be hemorrhage. Without her knowledge of Coumadin effects and the strict precautions which accompany the administration of this drug, the result could be life threatening. Just imagine the problems incurred with such a drug causing significant gastrointestinal or urinary tract bleeding, or the simple cutting of a finger, or a visit to the dentist to pull a tooth or cleaning, or surgical procedure.

It also must be considered, the many drug interactions which occur that increase the anticoagulant effects of Coumadin. Many simple over the counter medications such as aspirin increase the Coumadin effect. At the time Mrs. Owens received this medication, she was taking Equagesic, which contains aspirin; an antibiotic, Erythromycin, which enhances the anticoagulant effect, and a cough medication called Tussionex, which enhances the anticoagulant effect. Also, it is noted that enhanced anticoagulant effects are seen in females being more sensitive to these agents.

I cannot overemphasize the gravity of this mistake. As stated before, too many individuals are taking medications without making sure its appearance is the same as previously taken. The individuals are trusting that the medication is correct, or elderly individuals' inability to make sure it is correct. In an operation where there are no checks an balances, the consequences of an individual attempting to save money for themselves or an insurance carrier, the results can be monumental when a life is lost.

Respectfully, Theron C. Cash III, Pharmacist, 2936 Bray Road, Virginia Beach.

Senator SASSER. Thank you very much, Mr. Kellum.

I want to ask a few questions and then I will yield to my colleague, Senator Heinz, who we are pleased to have with us today.

Mrs. Owens, had you not been accustomed to taking this particular medication and accustomed to the size of the tablet itself and the color of it, would you have been suspicious that there had been an error in filling your prescription?

Mrs. OWENS. No, I would not. I would have had nothing to compare it to.

Senator SASSER. Well, did any information come with the drug that you received?

Mrs. OWENS. No.

Senator SASSER. Was there printed information telling you what the drug was, what the side affects might be, what the contraindications were for taking it, et cetera?

Mrs. OWENS. No, sir.

Senator SASSER. So all you got was simply this pill bottle here, with the label on it, Corgard?

Mrs. OWENS. That is right, yes.

Senator SASSER. Let me ask you, based on your experience, do you feel that information and perhaps even a warning about prescribed drugs should accompany the mail order package? In other words, based on your experience do you feel it would be good policy for the mail order drug firms to enclose with the medication information relative to the medication itself?

Mrs. OWENS. Yes. In that case, if they had sent the right piece of paper along with it, for Coumadin and not Corgard.

Senator SASSER. Well, the statement of your pharmacist indicated that you no longer intended to use a mail order service; is that correct?

Mrs. OWENS. That is right.

Senator SASSER. Why did you go to the mail order firm to begin with?

Mrs. OWENS. As I said, my husband is retired civil service and we live on a specific income, and $5 for a 3-month prescription sounded pretty good.

Senator SASSER. So you went to the mail order firm because the prices, of course, were lower?

Mrs. OWENS. Were lower, yes.

Senator SASSER. And the quantities for the same price were substantially larger, I assume.

When the anti-hypertensive medication was prescribed to you by your physician, your doctor, did you feel that the explanation that he gave you for taking the drug was adequate?

Mrs. OWENS. My doctor told me what the side effects would be and also, when it was filled, either Ted Cash or Mr. Pridgett, the other pharmacist at Giant, explained to me what the side effects would be and what not to drink or eat along with it.

Senator SASSER. But none of those admonitions or instructions accompanied the mail order drug?

Mrs. OWENS. No.

Senator SASSER. I see. Now, I will ask you, Mr. Kellum, as a practicing pharmacist, have you ever encountered a similar incident in which someone has received drugs by mail that were the wrong dosage or the wrong drug?

Mr. KELLUM. One other instance, sir. One of the Federal employees had received the wrong strength rather than the wrong medication and there were not any severe effects to that.

Senator SASSER. On the average, how many prescriptions would you fill or check an hour at your pharmacy?

Mr. KELLUM. In a 6½ hour period we fill approximately 95 to 120 prescriptions in a 6½ hour period, so that is not too many. This figures out about one every 2 minutes at the most.

Senator SASSER. What do you consider to be the maximum safe amount of prescriptions that could be filled per hour, or checked per hour by a pharmacist? Or do you have an opinion on that?

Mr. KELLUM. I personally did not have an opinion so I checked with several large-volume pharmacies in our particular area, one being the U.S. Navy, who fills a tremendous number of prescriptions and uses technicians and so forth. For a pharmacist to check more than 60 prescriptions in an hour is asking entirely too much. Most pharmacists are not called upon to do that.

Senator SASSER. Based on your experience, is there any difference in the error rate between prescriptions that might be filled by a local pharmacist and those filled by a mail order firm, or have you had enough experience to form a judgment on that?

Mr. KELLUM. Yes, sir. In my 17 years of practice—we are all going to make mistakes. I know of two or three that have been called to my attention, either by myself or by the patient themselves in that 17 years, so we are all going to make errors. But I think the beautiful part about the existing system is that you have an opportunity to immediately correct a situation, and I find myself after work picking up a prescription from a lady who got the wrong medication as far as the strength of a particular ophthalmic drop, or eyedrop. The strength was incorrect and I corrected that error. It was done that day, not 6 weeks or 6 months later.

Senator SASSER. Well, do you have any procedure in the pharmacy where you work that would make sure that an error similar to the one that Mrs. Owens encountered would not occur?

Mr. KELLUM. Yes, sir. We maintain a four-check system. The pharmacist must check the prescription at least four times before it goes over the counter, and the fourth time is with the patient and the medication in hand and properly advising her as to how to take the medication, when to take it, and what things to avoid if she is on other medications at that particular time.

Senator SASSER. Well, thank you very much Mr. Kellum and Mrs. Owens.

Senator Heinz?

OPENING STATEMENT OF SENATOR HEINZ

Senator HEINZ. Mr. Chairman, I have a statement I would like to put in the record. I am going to have a few questions to submit to our witnesses in writing, but I am going to reserve my time.

Senator SASSER. Thank you. Your statement will be included in the record.

[The statement referred to follows:]

PREPARED STATEMENT OF SENATOR HEINZ

Mr. Chairman, thank you for this opportunity to review matters pertaining to mail order pharmaceuticals. As we know, the delivery of prescription medications and other pharmacy services directly to consumers' homes plays a vital role in preserving the health and welfare of millions of Americans who have limited physical access to walk-in retail pharmacies. It is highly desirable that this service be provided in a manner that preserves our commitment to high quality health care.

Those who may need—or be completely reliant upon—mail order pharmacies include older Americans who are homebound, the disabled or the handicapped, those living in rural areas and those without access to public or private transportation. What we should be seeking as policy makers is an approach that ensures both access and quality in health care.

There are really two separate issues before this subcommittee. One is the operation and safety of mail order drugs provided to Federal employees through the Federal employees health benefits program—a matter which this subcommittee has every reason to oversee. The second is more general, and involves the overall operation of interstate mail order pharmaceuticals.

With regard to the latter question, as I understand it, mail order drugs make up less than four percent of the total prescription drug market, or approximately 60,000,000 prescriptions out of 1.5 billion. Although this number is small, it is expected to increase in the next few decades.

It is also my understanding that mail order drugs are primarily maintenance drugs. That is—they are drugs which individuals take on a regular basis, over a long period of time; seldom are mail-order operations used to provide prescriptions for acute needs.

Where any means of delivering pharmaceuticals to the public has questions of safety outstanding, I necessarily am concerned. An essential question for this hearing is whether there are any realiable indications that mail-order pharmaceuticals are any less safe than any other means of dispensing drugs. For example, I am advised that the number of mail-order packages actually tampered with, that is, those with broken seals or incomplete sealing as a result of shipping is minimal. Thrift Drug estimates that less than one-tenth of one percent of their mail-order drugs have this problem—a problem which is not present in retail drugs.

With regard to the first question before us—that of the Federal program—I am aware of a very specific interest of importance to the more than one million Federal employees who subscribe to Blue Cross/Blue Shield and receive mail order drugs. Today's testimony will help us learn whether or not improvements need to be made in this Federal program.

Returning to the overall question of mail order drugs, as a general rule—and focus—for us as legislators, we need to be convinced that there are significant problems, particularly if we are going to discuss limiting the access of the elderly, the sick, and the handicapped to maintenance drugs, for which they have a long-term need. Otherwise we may be legislating less access in the name of perhaps non-existent or minimal benefits in the safety or quality of care.

Thank you, Mr. Chairman.

Senator SASSER. Well, I want to thank you, Mrs. Owens, for your testimony here today. It has been most helpful and I think it is important that this problem be called to the attention of those who have the responsibility of dealing with these matters.

You are very good to come here and share your experience with the Subcommittee here today.

I thank you, Mr. Kellum, also for appearing.

Mrs. OWENS. Well, thank you, and I hope something can be done about it.

Senator SASSER. Our next three witnesses are registered pharmacists who will be testifying before the Subcommittee anonymously at their request. In order to protect these witnesses, I am going to now ask that the hearing room be cleared just briefly so that these witnesses may be seated. After they are seated, the public will be readmitted to the hearing room and the hearings will proceed, so our hearings will be temporarily recessed for that purpose.

[Brief recess.]

Senator SASSER. The Subcommittee will come to order. Our next witnesses are three registered pharmacists that were previously employed by a national mail service pharmacy and they will be testifying, at their request, in an anonymous capacity and their individual identities will be known only to the members of the Subcommittee and our staff, and throughout the course of this inquiry their identities will remain confidential.

I might say that these three pharmacists, formally employed by a national mail service pharmacy are here to testify about their observations, based on their on-the-job experience, as to safety and soundness standards followed by the national mail service pharmacy with regard to the correct filling of prescriptions and dispensing of prescription drugs.

I want to commend the witnesses for coming before the Subcommittee today and giving us the benefit of your observations. I think they are going to be very, very important. We intend to consider your testimony very carefully so that we may make appropriate judgments about the nature of the quality controls that should and must be practiced when prescription drugs are dispensed through the mail.

We are identifying the three witnesses as Pharmacist 1, Pharmacist 2, and Pharmacist 3, and I will ask each of you if you have a statement today to present or to submit for the record.

Pharmacist 1?

TESTIMONY OF THREE ANONYMOUS WITNESSES, FORMER EMPLOYEES OF A NATIONAL MAIL SERVICE PHARMACY

PHARMACIST 1. Yes, I have a statement I would like to make.

I am testifying today for personal and professional reasons. In my short stay at National Rx, I witnessed a system that not only caused errors, but actually guaranteed errors to occur. The use of an across the board high speed quota system, untrained technicians, 50 to 80 hour work weeks and 14 hour days, as well as a poorly designed filling system, insured mistakes would be made.

When I voiced concerns over the quota system and the high percentage of errors that were seen by pharmacists on a daily basis, I received pep talks and platitudes. I attempted to rectify the situation through the proper channels—upper management and direct supervisor. Getting no positive response in that direction, I contacted a high official of the State Board of Pharmacy. This also proved fruitless. He was more interested in my identity than any safety or legal problems at National Rx.

I could not in good conscience continue working for an employer that talked quality and safety but practiced speed and profit no matter the consequence. I believe that National Rx, as presently operated, is a safety hazard to those it serves and a poor reflection on the profession of pharmacy.

Senator **Sasser**. Thank you, Pharmacist 1.

We will now hear from Pharmacist 2. Do you have a statement that you wish to make?

Pharmacist 2. Senator Sasser, I have a written statement for the record. I ask that it be included in the record and I wish to make a short oral statement at this time.

Senator **Sasser**. Well, your written statement is lengthy. It will be included in the record [1] and we would be pleased to hear a brief oral statement.

Pharmacist 2. Thank you, Senator.

Earlier today I submitted to the Committee a 4-page written statement with 14 pages of photo-copied articles. The written statement is an attempt to answer the questions in the July 29, 1987, letter from Chairman Jim Sasser of Tennessee. The photo-copied articles are from my own mail order pharmacy files and were offered in an attempt to provide some background food for thought about mail service prescriptions.

My concern for the safety of the American public being serviced by National Rx Services, Inc., in particular, and mail order pharmacies, in general, brings me here today. I appreciate your timely study of this problem and am willing to answer any additional questions from the Committee.

Thank you.

Senator **Sasser**. Thank you very much. We will have some additional questions in just a moment.

Now we would like to hear from Pharmacist 3. Do you have a statement that you wish to make?

Pharmacist 3. Yes, Senator.

My presence here today is not a pleasant experience, but I am here because I feel a professional obligation to protect the public.

When I accepted the position as pharmacist with National Rx Services, Inc., I was very excited about becoming part of this new, although controversial, trend in pharmacy. As problems with the system became apparent, the pharmacists as a group brought them to the attention of management. What followed was several months of no action, which showed an obvious lack of concern.

This drove several frustrated pharmacists to contact upper management. It was not until after this contact was made that there was even an attempt on a local level to rectify some of the problems. Upper management met with several pharmacists and seemed to care about our concerns. As months passed, it was obvious that quantity and profit were more important than quality. There seemed to be little concern about pharmacists' fatigue, which we feared would result in more prescription errors.

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[1] See p. 92.

The plant was being operated with a "chain gang" type philosophy. National Rx Services, Inc., classifies itself as a mail service pharmacy. In its fast growth, it has lost sight of its obligation to the public as part of the health care team. I believe that the pharmacists have done everything possible within the organization to correct a hazardous situation.

When pharmacists lose the ability to influence the standards and ethics of an organization that calls itself a pharmacy and therefore jeopardizes the lives and health of the general public, then we as pharmacists have lost control of our profession. The ethics and standards of the profession of pharmacy must not be determined by profit margin. This is why I am here today.

Senator SASSER. Well, thank you very much.

I am going to ask a series of questions now of all three of our witnesses, and I will ask you each, if you will—or if you can—to respond to these questions.

Now, as I understand it, each one of you is a registered pharmacist; is that correct?

PHARMACIST 1. Yes.

PHARMACIST 2. Yes.

PHARMACIST 3. Yes.

Senator SASSER. You are certified in the State where you were employed by National Rx Services; is that correct.

PHARMACIST 1. Yes.

PHARMACIST 2. Yes.

PHARMACIST 3. Yes.

Senator SASSER. The registration for all three of you is current; is that correct?

PHARMACIST 1. Correct.

PHARMACIST 2. Yes.

PHARMACIST 3. Yes.

Senator SASSER. I will ask each of you, have you ever been subject to any disciplinary action by any State Board of Pharmacy that you have certification with?

PHARMACIST 1. No.

PHARMACIST 2. No.

PHARMACIST 3. No.

Senator SASSER. I understand that each of you worked for varying lengths of time at National Rx Services, Inc. Now, when you left the firm, did you resign or were you terminated from the position by National Rx Services?

PHARMACIST 1. I resigned.

PHARMACIST 2. Resigned.

PHARMACIST 3. Resigned.

Senator SASSER. Now, would each of you briefly give the Subcommittee your general appraisal of the safety and soundness standards that were followed in dispensing prescription drugs at National Rx Services, Inc., where you were employed. We will begin with you, Pharmacist 1, unless another would like to begin.

Pharmacist 2, would you like to try that question?

Pharmacist 2. Senator Sasser, I have gone to some length in my written testimony on this point. However, I will briefly bring to your attention that during the latter part of my time with the company, I thought that the standards for the practice of pharmacy were neither safe nor sound.

The quota system, the amount of time we were required to work at checking prescriptions without breaks away from the desk, the pressure for productivity when quality was preached and actually quantity was rewarded led to an atmosphere, with other things, that was not conducive to the proper practice of pharmacy.

I felt that to stay at National Rx Services, in order to survive the quota system and the productivity expected of me, I would have to lower the standards which I had acquired and set for myself throughout my pharmacy practice.

Senator **Sasser**. What was the quota system? How many prescriptions? Just tell the Subcommittee how the system worked.

Pharmacist 2. Senator, all technicians, clerks and pharmacists at National Rx Services are expected to work under a quota system. I cannot speak for the technicians and clerks. However, pharmacists were expected to fill 50 prescriptions per hour for every hour at their desk.

Senator **Sasser**. Were you filling prescriptions or were you checking prescriptions?

Pharmacist 2. We were checking prescriptions.

Senator **Sasser**. Who actually filled the prescriptions?

Pharmacist 2. They were filled by pharmacy technicians.

Senator **Sasser**. So the pharmacists themselves checked the prescriptions that had been filled by technicians; is that correct?

Pharmacist 2. That is correct, Senator Sasser. We checked the prescriptions that had been filled by technicians, and if we found that the prescriptions were properly filled, it was our responsibility to properly label it, properly pack it, and properly send it off to the patient.

Senator **Sasser**. How many prescriptions were you required to check an hour?

Pharmacist 2. Fifty.

Senator **Sasser**. What happened if you failed to check 50 an hour on a regular basis?

Pharmacist 2. I cannot speak for other pharmacists. However, one week I did fall to 49 and I was called into the pharmacy supervisor's office and spoken to about it.

It was common practice to call every pharmacist into the Chief Pharmacists office and reprimand them if they failed to meet the quota. Technicians were also expected to meet the quota and had to submit sheets of paper with an Rx number sticker for each Rx filled. They were under a lot of pressure to fill at least 60 at the baker cells and 50 at the verticals. This can be documented by asking any technician or obtaining the quota sheets that tech's were required to submit daily. When they—the supervisors—were calling pharmacists in for not meeting the quota, five out of eight pharmacists in my row were reprimanded. I was one of them.

Senator **Sasser**. Was there any reward given to pharmacists who checked more than 50 prescriptions an hour?

Pharmacist 2. Yes, Senator. For every prescription above 2,130 checked per week a 15-cent per prescription bonus was paid.

Senator **Sasser**. Did either of you three pharmacists ever receive a bonus for checking more than the required quota of prescriptions?

Pharmacist 1. Yes. Twice I received the bonus, but both of those weeks I worked long hours. It was not due to my speed.

Senator **Sasser**. Are there instances in which either one of you are aware that individuals received incorrect prescriptions or inappropriate prescriptions from the National Rx Services while you were working there?

Pharmacist 1. Yes. Every pharmacist that I worked with I know received incorrect prescriptions on a regular basis. It became so commonplace that I began to keep a log of how many prescriptions I would receive on a daily basis that were incorrect. This log showed me that at least 5 percent of the prescriptions that I encountered were incorrect—either incorrectly filled or incorrectly screened or incorrectly typed as far as directions.

Senator **Sasser**. Now, these would be prescriptions that had been filled by the technicians that would come to you that were incorrect?

Pharmacist 1. Right.

Senator **Sasser**. That would be approximately 5 percent, based on the log that you kept?

Pharmacist 1. Yes.

Senator **Sasser**. Now, are you aware of any individuals, ultimate consumers of the drugs, who received incorrect prescriptions?

Pharmacist 1. Yes, I am

Senator **Sasser**. How many individuals are you aware of? Just give us the circumstances of how you came to know about that and what the circumstances were.

Pharmacist 3. If I may answer that question?

This information about prescriptions being mis-filled and the customers having received them was kept in another area of the plant that we were not allowed access to, so we knew of a few by way of reprimand by management to be more careful. But we were not made aware of that on a regular basis.

But there were instances where, like I say, on reprimand we were told that this happened, that got out—things like that.

Senator **Sasser**. Was the area where this information was kept accessible to you? Could you as a pharmacist check and see who got an incorrect prescription or which pharmacist was responsible for letting that prescription get by?

Pharmacist 3. As a matter of fact, we were told several months before that this information was kept in a locked briefcase by one pharmacist and one pharmacist only. We had no access to it. We were shown a piece of paper on which records were kept but we were not allowed to view it.

Senator **Sasser**. Well, if someone got an incorrect prescription—that is the ultimate consumer received an incorrect prescription—let's say, if someone had an anti-hypertensive drug like Corgard prescribed for them and they received Coumadin, a blood thinner by mistake, was there any way they could contact National Rx Services and tell them of the error?

PHARMACIST 3. The customer?

Senator SASSER. Yes.

PHARMACIST 3. Yes. The customer upon contact would call National Rx Services and ultimately talk to the customer service department. They would send the proper medication along with packaging for the customer to send the improper medication back to them.

Senator SASSER. What happened when the improper medication came back? Do you know?

PHARMACIST 3. OK. If the prescription was filled improperly, shortly thereafter the pharmacist would be called into the supervisor's office. They called that a Class A error and the pharmacist would be written up for that. The pharmacist would be shown the prescription and the error and the bottle. That would go permanently in the pharmacist's file.

Senator SASSER. Well, the drugs themselves that were shipped back were not re-used, were they?

PHARMACIST 3. We have no idea.

PHARMACIST 2. Senator Sasser, they were not. It was the practice that every prescription which had been outside the plant on return would be destroyed.

Senator SASSER. Now, with regard to the service individuals who took the telephone calls from individuals who had received the wrong prescription, were they pharmacists?

PHARMACIST 1. No, they were not.

Senator SASSER. Now, how many people were receiving telephone calls from individuals who received the wrong prescription? Do you know?

PHARMACIST 2. Senator, at one time I would guess it was between 8 and 10. However, the customer service department was recently renovated and modernized and I believe now it would be safe to say 10 to 15.

Senator SASSER. Well, you mean 8 or 10 telephone operators or technicians were kept busy receiving principally complaints? Is that what they were receiving?

PHARMACIST 2. Yes, Senator. I would say the majority of calls would be from patients who had ordered prescriptions perhaps more than 2 weeks ago, and since they had been promised in their plan that the prescription would reach them from 10 to 14 days, they would become concerned and call in to find out if the prescriptions had been received, if they had been sent and what was the status of them at that point, many times, because in fact they were running out of their needed medication at home and were concerned that the new prescription would not reach them in time.

Senator SASSER. Do you know what percentage of the calls that came in were a result of incorrect prescriptions? What we are trying to ascertain here, if you know—certainly, we do not want to put any words in your mouth at all—but you have indicated that about 5 percent of the prescriptions that came up to the pharmacists from the technicians were in error—at least that is corroborated by the diary that Pharmacist 1 kept.

We are trying to determine what percentage of incorrect prescriptions got out the door to the ultimate consumer.

PHARMACIST 2. Well, Senator, considering about 50,000 or so prescriptions were going out of the plant every week, at that rate, even 1 or more than 1—which is too many—would still be a small percentage, considering the fact that so many prescriptions were being sent out.

Senator **SASSER**. So you are telling us that you do not know what the ultimate error rate was?

PHARMACIST 2. I do not know.

PHARMACIST 1. No, they never let us have access to any of those records. That was a closed department and we had no access. We could not even look at prescription files, let alone customer service files.

PHARMACIST 2. If I may add one note on this, however, in January and February we were particularly busy, working 60 hours per week due to the fact that——

Senator **SASSER**. This was 1987?

PHARMACIST 2. We are speaking of January and February of 1987. We did take on a number of large plans and were just swamped. During that time we worked 60 hours per week and there was a lot of pressure. There were so many mistakes made during those 2 months that an employee from the New Jersey office was sent into the customer service at our plant and sat at a desk in the customer service for a few days doing nothing else but opening returned mistakes and recording them.

Senator **SASSER**. Now, with regard to the quota system that was established for the pharmacists, did this also apply to the technicians who filled the prescriptions?

PHARMACIST 1. Yes. What I heard from the technicians verbally was the baker cells were expected to meet 70 Rxs per hour—70 fills per hour. At the verticals, it was 60 per hour. They did not receive a bonus.

Senator **SASSER**. Now, what is a baker fill as opposed to a vertical?

PHARMACIST 1. A baker cell is an automatic counter. It is like an automatic counter device, except it is very large.

Senator **SASSER**. It would count the number of pills?

PHARMACIST 1. Right.

Senator **SASSER**. And a vertical fill is what?

PHARMACIST 2. A vertical fill would be more like what you would find in a local pharmacy or in a hospital. The drugs were actually aligned on shelves, not numerically or alphabetically or in any order, but were assigned positions on a long shelf which rotated and a locator label at the bottom of the prescription would tell the technician on which shelf the drug would be found and at what location on that shelf the drug would be found.

Senator **SASSER**. Well, let me ask you this question. Under this system, how could a prescription for Corgard be filled with Coumadin and then the bottle labeled Corgard with that label being pasted over the generic chemical formula for Coumadin?

PHARMACIST 3. That could be done several ways. Let's say, for instance, it was in a baker cell. The technician—who was not responsible for reading the name of the drug, only the location—would read the wrong location. If it said baker cell 7, then they would mistake it as baker cell 9, and Corgard was in 7, Coumadin was in 9.

If it was a drug in the verticals, then what would happen would be, on the shelf Corgard and Coumadin may be next to each other, and instead of reaching for one drug, they would accidentally reach for the drug next to it. So therefore the label would still say, because the technicians were not responsible for reading the names of the drug, only the numbers of the locations.

Senator SASSER. So, there was no cross-check between number of the bin where the drug was kept and the name of the drug? In other words, the technician would simply reach into the bin by number and no matter what was in that bin, the technician would fill the prescription with that drug?

PHARMACIST 2. That is correct, Senator. In fact, when the bins were incorrectly filled, then it was the responsibility of the pharmacist to catch that at the desk in checking—get up out of your seat, go to the bin, check it, make sure what had happened, have a technician empty that bin and proceed to fill it properly.

Senator SASSER. Did you say these technicians had a quota of 70 prescriptions per hour?

PHARMACIST 1. Seventy fills per hour.

Senator SASSER. That was for the baker machine and the vertical machine?

PHARMACIST 1. That was for the baker. The vertical was 60, because it was not as accessible.

Senator SASSER. So on the baker machine they were filling more than one prescription per minute, and on the vertical machine they were required to fill one prescription per minute?

PHARMACIST 1. Yes, correct.

Senator SASSER. And on the vertical I assume they had to get up and walk around; is that correct?

PHARMACIST 3. No. They did not walk around. It was a huge machine that rotated, so therefore, they would use a computer-type operation to punch the shelf number, and it was either shelf 1 or shelf 18. But when they had a drug that was on shelf 12 and they were on shelf 1, they would press 12 and it would come around to 12, so therefore the time consumption was in there.

Senator SASSER. Well, did the technicians themselves ever see the individual pills themselves that were going into the bottles?

PHARMACIST 2. On the vertical shelf unit, yes, because the tablets and capsules were counted by a machine called a Kirby-Lester Counter, and if the technicians had their eyes open, they should be noticing the type of tablet or capsule that was going into the counter machine. However, it is possible, if one would be trusting enough to believe that that bin was always filled properly then, of course, the wrong tablet or capsule would be counted and sent on.

PHARMACIST 3. If I may add, most of the technicians were not concerned about the look of the tablet. They were concerned basically with the location number, because they were rotated so they did not get the opportunity to learn a certain group of drugs. So from one day to the next they would be in a different area and the drugs would look differently.

So they really had no concern about what the drugs actually looked like. Most would not be able, or would not even look to tell Coumadin from Corgard.

Senator SASSER. So, the technician would not become acquainted with the fact that Coumadin was a pink pill and that Corgard was a lavender blue pill?

PHARMACIST 3. That was totally our responsibility.

Senator SASSER. Now, did you or any of the other pharmacists at the National Rx Services ever complain about a quota system to the local plant management? If so, what was the reaction of the plant management to the pharmacists complaints?

PHARMACIST 1. Well, I complained one-on-one to my direct supervisor and the upper supervisor. I also complained in group meetings to the direct supervisor. I also asked them in the group meetings what the quota system was for the technicians. They would not tell us.

All of the pharmacists got together and were against the quota system. We all had a meeting after work one night and 27 of us showed up and 27 of us voted to have the quota system removed from the plant, not only for the pharmacists but for the technicians as well. Also, screening was under a quota system. They were supposed to screen 60 per hour, which is ludicrous to expect an untrained person to read 60 prescriptions per hour and decipher the signature, the drug, put down the location number and days supply and refills. It was a very hard task.

Senator SASSER. Now, you have got a new procedure here that I was not aware of, screening. What is that?

PHARMACIST 1. Screening is when the brand new prescription comes in, and usually a technician—I would say 90 percent of the time—a technician would look at the brand new prescription, read the drug, pull it up on the computer, write down the drug code that would help the technicians find it in the proper cell. The typist then would type in that drug number, that code number.

Senator SASSER. But the screener had the responsibility for reading 60 prescriptions an hour?

PHARMACIST 1. Correct. Yes, they would have to read not only the drug name, but also the directions, because that would help you determine the quantity to give the person.

Senator SASSER. Now, these prescriptions that came in, were the majority of them typewritten or handwritten?

PHARMACIST 3. The majority were handwritten.

Senator SASSER. Do you mean they were reading physician's handwriting?

PHARMACIST 3. Yes.

Senator SASSER. My word. They must have been geniuses to read that.

PHARMACIST 3. Not all the time. There were several times—those were some of the errors that the pharmacists would catch, because of misread prescriptions.

Senator Sasser, I would like to point out that this one position is, if not as equally as important as checking, more important. If, at that stage, the prescription is given the wrong drug code, there is no way that anyone else in that plant can ever rectify that mistake.

Senator SASSER. In other words, if this screener misreads the name of the drug or misreads the strength of the dosage and that gets on the label, then there is no way to correct that. In other words, it is going to go out the door with that error on it, because the technician will fill it pursuant to the label the screener put on the bottle or on the order, and the pharmacist who checks the filling that the technician performed will also be guided by the label on the order; is that correct?

PHARMACIST 3. Yes, and that provided us major complications. The pharmacists at their desks were assigned the responsibility of doing everyone's job. They had to check to make sure the screener did it right. Then they had to check to make sure the typists did it right. Then they had to check to make sure the technician did it right.

We had to do over again each and every step in order to verify it.

Senator SASSER. And all the time maintaining a quota of 2,130 prescriptions a week, or 53 prescriptions an hour; that is correct, is it not?

PHARMACIST 1. Yes.

Senator SASSER. What happened when you found an incorrect prescription and you had to take the time to go back and check the bin or something like that. How did that count on your quota system?

PHARMACIST 2. It was not taken into consideration.

Senator SASSER. So, if you spent 5 minutes trying to correct an error, then you just had to pump out that many more prescriptions to make up for the error rate of a technician. Is that a fair assessment?

PHARMACIST 2. Or miss your afternoon 10-minute coffee break.

Senator SASSER. So there was really no incentive, other than your own sense of conscience and sense of professional pride that would induce you to work diligently to spot the mistakes. In other words, to some extent you would be punished for spotting the mistakes that others had made, because you would have to work that much harder to meet the quotas; is that not correct?

PHARMACIST 3. Yes, that is correct. Not only would it take extra time to spot it, but if you were a conscientious pharmacist and you got one drug instead of another and wanted to make sure that no other pharmacist got the same thing, that the baker cell was filled properly, then it would take you additional time. Whereas, if you were not so conscientious, you would not worry about what the other pharmacists received or what was in the baker cell.

So that was the difference. The system perpetuated the lackadaisical attitude of not caring about anything except what was exactly in front of you.

Senator SASSER. Now, describe the qualifications, if you will, of the technicians or those who screened the prescriptions—that is, those who read the prescriptions or those who were the technicians. Generally, what were their educational backgrounds? Did they have any particular qualifications or expertise for doing this?

PHARMACIST 2. Senator Sasser, I believe those were varied. I did know technicians who were currently taking university courses. I did know technicians who only had high school degrees. I did know technicians who were professionals in foreign countries, for example, a chemist. We also had a foreign physician as a technician. So as you see, a variation from a foreign physician to a technician with only a high school degree just runs the gamut.

Senator **Sasser**. How about the screeners themselves, those who read the prescriptions. Did they have any particular qualifications or were they also varied?

Pharmacist 3. There was no special training, to my knowledge, given to the screeners. Screening was a rotation for the technician; baker, vertical, screening. Those were the three areas, mainly, they were rotated through. So for the time off their feet they were put into screening.

Some had experience in pharmacy, some did not.

Senator **Sasser**. Now, why did you three pharmacists choose to resign from National Rx Services?

Pharmacist 1. Well, I chose to resign because I had exhausted every means available to try and rectify what I thought was a suicidal job. I was going to either kill someone or I was going to kill myself as far as professional future. Every night I would go home and dread and wonder if I had made a mistake that would hurt someone.

I think the situation that caused me the most upset was a baker cell mixup of approximately 4 days running where two very different pills were mixed—one for breathing, one for a heart condition, both white, small pills. You could not tell the difference. This mix up is documented in my log.

The baker cells held at least 500 to 1,000 pills. This baker cell was mixed on one day. We found a prescription the next day and that person, that pharmacist that found it, was conscientious enough to come and tell the other pharmacists that that person could reach about it. The technician was not pulled from the bakers.

The first day the error was detected only about half the pharmacists were notified. When a mix up like this occurs it is very important that everyone checking Rx's knows about the situation. The technician could have filled 30 Rx's for that same drug in a matter of hours. Lanoxin and Proventil are both prescribed so often, that is why they are located in the baker cells. It was only luck that the first pharmacist even notified the difference. It was very hard to spot under the best conditions.

That same technician messed up the same baker cell 3 times in one week. God only knows how many prescriptions did get out the door that week that were mixed, the baker cells were mixed, because all the pharmacists did not know that the baker cell was mixed, and it was extremely difficult to tell because they were both small white pills with only embossed writing—no differentiating factors.

Management's response to that was not to announce it over the loudspeaker system, so that some pharmacists were not even aware this mix was occurring. It took approximately one week for them to pull the technician off the baker cells, finally.

Senator **Sasser**. Do you recall the names of these two pills that were mixed?

Pharmacist 1. Lanoxin .25 and Preventil 2 mg, as well as Provera 10 mg. It was several mixes.

Senator SASSER. Well, now, one of the pills was, you said, for breathing. What do you mean?

PHARMACIST 1. It was something that would help people with asthma to breathe, a bronchial dilator.

Senator SASSER. And the other pill was for a heart condition?

PHARMACIST 1. Yes.

Senator SASSER. What would that do to help the heart patient?

PHARMACIST 1. It would help the heart beat stronger and slower. It just takes a load off the heart so it does not have to work so hard.

Senator SASSER. So your fear was that the asthma patient was going to get the heart medication and the patient with the heart problem was going to get the asthma medication?

PHARMACIST 1. Right. Lanoxin is a toxic substance for those who do not need it. Also, the Preventil may cause the heart patient high blood pressure and arythmia.

PHARMACIST 3. And the dosages of the two tablets were very different. One was a once-a-day, maybe twice-a-day. The other one could be taken four times a day, which would prove toxic for Lanoxin.

PHARMACIST 1. Right.

PHARMACIST 3. There was another instance where Parafon Forte, a muscle relaxant, was mixed with Isordil, also a heart pill, and they looked exactly the same.

Senator SASSER. Well, what would happen to the heart patient if he took the muscle relaxant rather than his heart medication? Or do you know?

PHARMACIST 3. He would suffer from, most likely, an irregular type heartbeat, just as in discontinuing his medication, which is not advised with any heart medication.

Senator SASSER. So Pharmacist 1, it was really your conscience and your sense of professionalism that dictated your resignation from the mail order pharmacy company?

PHARMACIST 1. Correct. I learned that at least one of those prescriptions that I have referred to, one of the Preventil-Provera mixes, Preventil-Lanoxin—whatever—there were several mixes in that week. All of them were white pills, small. I learned that there was one that had gotten out and it just became clear to me that that was not the place where I wanted to work.

Senator SASSER. Pharmacist 2, why did you resign?

PHARMACIST 2. For various reasons, but at the end it all came down to the bottom line that I was terribly disappointed in the way that pharmacy was at that time—the time I left—being practiced at the facility.

At one time—well, the first half of my stay with National Rx Services, during that time we were able to practice pharmacy very well, with half a day on the line at our desk and half a day off doing other duties, so that in fact when you got to work each day you knew that you would either work hard in the morning checking prescriptions and then be doing other duties in the afternoon, which would refresh you, or you would be refreshed in the morning so that in the afternoon you could get down and get the work done.

Plus, there was not the push for productivity and we had time to write to patients if they asked us questions. We had the time to do everything properly, and as the months went on, it became more and more apparent that it was not getting better, it was getting worse. I got to the point where I thought if I stayed any longer, I was going to, for the first time in my life, work and provide service to a patient which was less than the high standards which I had practiced under for all of these previous years.

Senator SASSER. Thank you. I might ask you this. Why did it change there, from the time when you could have the mornings, perhaps, to write to your patients or your consumers? What happened to make the tempo of work change?

PHARMACIST 2. There was a change in immediate management. On or around October of 1986 our chief pharmacist, who had mutual respect for pharmacists—we had gotten along with him very well. He was a very good understanding pharmacist who had been in the profession for 30 or more years and pharmacy was practiced as it had been during the time he had been a pharmacist, and a supervisor who was our go-between with management. If management would say, I want the pharmacists to do this, that and the next thing, the supervisor would say, my pharmacists are not going to do that.

So, in fact, we were practicing pharmacy as it should be practiced, but our productivity was not as great as perhaps upper management thought it should be. So therefore, those two, the chief pharmacist and supervisor pharmacist, were transferred out of the positions and two younger pharmacists were brought in to take over and at that time conditions deteriorated rapidly.

Senator SASSER. Well, your productivity rate might not have been as high under the previous pharmacist who had been a pharmacist for 30 years, but how about your error rate?

PHARMACIST 2. We would have meetings in the cafeteria, all the registered pharmacists, with the chief pharmacist and the pharmacy supervisor, and I remember months when we had no errors whatsoever, and I remember a month when we had one error, and there was a sort of feeling by some, well, one error is not too bad, considering all the prescriptions we send out. However, we were reminded by our chief pharmacist that one error is one error too many.

And so we went from no errors per month, one error per month, to what we have now.

Senator SASSER. Pharmacist 3, why did you leave the mail order drug firm?

PHARMACIST 3. I left National Rx Services in total frustration. I saw several things going on that absolutely should not, that I would never think would go on.

Senator SASSER. Would you speak up just a little bit.

PHARMACIST 3. I had seen several things happening and not corrected that I never believe a concerned pharmacist would not understand the importance of. One of the things, the Lanoxin-Preventil, the thing that disturbed me so greatly was that it happened on a Tuesday or Wednesday. The next day some pharmacists knew. One pharmacist found out over chit-chat at the lunchroom, and other pharmacists found out later on that evening, and the only excuse given was that it would be negative to announce it over the PA system, so therefore it was not done.

I saw pharmacists go into a panic when they found out that this mixup had happened 2 days prior, because everyone had dispensed one or the other of this medication and none of us knew whether we had dispensed the mixed bottles or not. There was a panic that went throughout the pharmacy and the chief pharmacist did not seem to be concerned. He was concerned with the fact that anyone taking a tour through the building would not hear about a mixup over the PA system. That disturbed me very much.

The pharmacists also voiced the fact that we were worked to the point of fatigue and that we were no longer alert enough to do all the checking required to make sure each and every prescription was correct after a period of 5 or 6 hours straight on line. They heard it, but there was nothing done about that. The situation continued to stay the same, as if they ignored it, then we would forget about it.

There were other instances where we had labeled certain technicians as not the type that had great attention to detail, therefore were constantly screening the wrong drug—constantly. We took these numbers—because everyone is assigned a number, most of the time we did not know their names—we took these particular numbers to management saying that these pharmacy technicians should no longer screen or should have special training in order to understand the adherence to detail.

This was not done. These pharmacy technicians continued to screen, we continued to have to find their mistakes and correct them and sent it back, and therefore prolong the length of time that the patient had to wait for his medication. Each time we turned a prescription back in for anything incorrect, it would take anywhere between 3 days to a week to get it back into the system again.

I found that management was totally unresponsive to the suggestions that we were making to make pharmacy better there. We saw that the bonus system perpetuated greed and that people rushed through checking prescriptions just to make the extra 15 cents per Rx. We decided that even though we liked the fact that we could make the money, we decided that it was a bad system because it perpetuated that greed at the expense of the patient. We asked that it be done away with and management said no.

Senator SASSER. You are talking about the 15-cent per prescription bonus for filling them as rapidly as possible.

PHARMACIST 3. Right.

Senator SASSER. Well, let me ask you this—each of you or all of you—during your time there, did the management ever indicate to you or to other staff pharmacists that problems were being encountered with the incorrect prescriptions going out to individuals?

PHARMACIST 1. Yes. There was a large meeting. Monroe Fauntleroy, chief pharmacist over all National Rx Services came to our plant one day and called everyone from the entire plant into the cafeteria and gave us about a 20-minute lecture on our horrendous error rate, is how he put it. He said it was totally unacceptable, that they were getting a lot of complaints from people receiving the wrong drugs.

There was a real problem we had with our packing area. We were so swamped that a lot of times they would pile the breadpans up—the breadpans were what the prescriptions were in—they would pile them up maybe 4, 5, 6, 7 high, full stacks of them, and they would fall over, and then everything would get mixed. Well, the careful packer would sort it out, but some did not.

So there were a lot of people getting the wrong drug for the wrong person, or a lot of errors occurring. So Monroe Fauntleroy came to our place and told us that it would not be acceptable. But he did not say that he was going to lower the quota system and he did not offer any suggestions on how it would be improved. He just said that it was not acceptable.

PHARMACIST 3. If I may add, about the packing system, National Rx Services boasted that each prescription was checked and packed by a pharmacist. That was not necessarily so. It was checked by a pharmacist, but not always packed by a pharmacist. Later on, as we received tours, as soon as the tour would come into the building, there would suddenly be a pharmacist assigned to the packing area and after the tour left, then the pharmacist would go back to her regular duties, therefore there were a lot of mixups that occurred in the packing area.

These were packed by the clerical and those who had the least education of the people who worked in the plant.

Senator SASSER. Well, were steps taken by management, following the meeting wherein the chief pharmacist complained about the error rate, were any specific steps taken to try to correct the problem?

PHARMACIST 3. The only steps that I can see being taken by management, as far as errors were concerned, were to call the individuals in on their particular errors. There was nothing done to actually change the system to reduce the amount of errors. It was the particular pharmacists who were written up and information put in their file concerning this.

Senator SASSER. Well, to you knowledge, did National Rx Services comply with all the appropriate State laws and regulations in dispensing prescription drugs? For example, if an individual from Florida was receiving a prescription that was dispensed from somewhere else—wherever you were located, and we are not going to say where you were located—were all applicable Florida laws and regulations regarding the dispensing of that prescription complied with?

What I am driving at, and I suspect you may know, is that in some States where a prescription is prescribed by brand name by the physician, it is illegal for the prescription to be filled using the generic drug. Do you know whether or not National Rx Services complied with all of those laws?

PHARMACIST 2. Senator, generic substitutions were handled at National Rx Services in the following manner—this was the company policy, and if it was followed properly, then no generics would have been sent out instead of brand. However, as we have said before, these mistakes would be made for other reasons, primarily productivity, greed for bonus, et cetera.

However, the company did set forth the following policy: In order for a pharmacist to send out a generic substitution, the pharmacist would have to have permission of the patient. That permission would be a signature on the back of the envelope, the plan envelope which was sent to the patient by his specific plan. You would need the patient's permission, plus the permission of the physician, and that oftentimes just meant that the physician did not say "dispense as written," or if the physician did not say anything, then you were to assume that had he wanted brand he would have said so, and in certain States he must say so in certain ways.

So therefore, if you had permission of patient, permission of physician, then a generic could be sent. However, as we have said, in the screening area technicians would be hurrying along and various mistakes would be made in this way. A patient would send in a prescription in a plain stationery envelope—a long envelope, a blue envelope, a pink envelope, whatever from the stationery drawer. Now, there is no way that a patient can give written permission on an envelope of that sort, but generic substitutions would reach my desk with this sort of envelope.

Another case would be that the technicians are so used to looking at the computer screen and are encouraged to always substitute generically whenever possible because the company sells the client on cost containment, and the company says to the client, when at all possible we will substitute generically, which will save you money. So therefore the technician sort of gets used to always looking at the first number but then zipping over to the next number or zipping down to the next number for the generic number. And in that case, generic substitution also reaches the pharmacist's desk.

So in those two cases, if the pharmacist catches the mistake, fine. If the mistake is not caught then it goes out.

Senator **Sasser**. Do either one of the other two wish to amplify on that answer? Or do you wish to let it stand as spoken?

Pharmacist 3. We were told, as you are aware, there are different—in some States you have to—the physician has to put DAW, dispense as written. In other States, they can have a choice of two lines at the bottom of their prescription in order to put their signature which will state one or the other. Some prescriptions have a box to check. If they did not actively do something to state a preference for the brand name drug, if they just wrote the brand name out and had one line at the bottom and the patient signed the back of the envelope, we would substitute generically.

Pharmacist 1. Yes, that was following State of Ohio law which says unless a physician physically writes DAW, then you do not have to dispense——

Senator **Sasser**. Well, let me ask you this question. As pharmacists you have worked for National Rx Services and you have worked for other types of pharmacy operations, some pharmacies of the retail nature.

Now, could you in your own words compare the safety and soundness standards with regard to the dispensation of prescription drugs in your various places of employment.

Pharmacist 2. Senator, I am glad you asked this question because one of the practices at the National Rx Services plant where I was employed bothered me from the beginning and never ceased to bother me to the last minute I was there, and that was the fact that in a retail setting or in a hospital setting, the original stock bottle is presented to the pharmacist by the technician so that the pharmacist may indeed read the label of the bottle and know that the tablets or capsules in that bottle are in fact what is in the vial and what should be dispensed.

However, at the plant where I worked, National Rx Services, we were never, never given the original stock bottle. So therefore, while we were checking, we had to check drugs by color, shape, code numbers, or a combination of these. Now, we were given some identification sheets. They were very old. They were not updated. Pharmacists had to trust each other to coordinate on the updates, and there were cases, in fact, when, in the plant, we had white generic tablets, no code, nothing. And in order to know what the tablet would be, the pharmacist would have to check at the source, and in other cases if a different company's generic had been in fact put into a bin from the generic that had been running perhaps for the last month or so, you could have a green generic tablet come to you instead of the blue one that you had last month and you would also have to go and check at the source.

Now, that is fine if a pharmacist is going to take the time and is ethical enough to do that. Otherwise, those may go out.

Senator SASSER. What do you say about this question, Pharmacist 1? How do you compare working—have you worked in a retail pharmacy as opposed to a National Rx Services?

PHARMACIST 1. Yes, I have.

Senator SASSER. What is your estimate of the safety and soundness standards that are followed by the two different firms?

PHARMACIST 1. Well, in a retail pharmacy you do have the stock bottles to look at. Also, you never deal with baker cells, which are the large bins where thousands of pills are put together and could possibly be mixed. That could not occur at a retail pharmacy because you are dealing right straight out of a stock bottle and you are looking at what comes out of it.

Also, you know what expiration date you are dispensing. You can look at the bottle you are dispensing from and see that it is a good drug. You do not know that when you are dispensing from National Rx Services. There have been times when I have gone back to the verticals and checked and there have been expired drugs on the vertical shelves, and if I had not checked just because I was not sure of the drug, it would have gone out.

The pharmacist had no control over any technican. The way Rx's were filled, the speed—that is, quota system—Rx's were checked and filled, the manner the Rx's were brought to the pharamcists desks, and the packing of larger Rx orders. We had no access to original Rx's except for the 60 seconds or less we glanced at them when we initially checked the order. We were routinely asked and pressured to work 9, 10, 11, 12 hour days, 6 days a week. Many pharmacists overworked themselves to a point of complete fatigue for the increased wages. The typists had no previous Rx experience and were continuously typing in the wrong directions. They were pressured by management to type fast. They were the fastest link in the chain. In fact management praised the typists for being the most professional sector in the pharmacy due to their high productivity. This was the type of mentality pharmacists had to deal with daily.

It was such capacity for error that it was overwhelming, and you do not have that capacity for error in a retail pharmacy. You are much more in control. So I would say it is not safe or sound.

Senator SASSER. Pharmacist 3, how do you answer that question?

PHARMACIST 3. Well, I would like to bring up another point about the labels and directions on labels. Before I left, I found that I felt somewhat compromised when the label came with the directions slightly wrong. I would find myself using white-out or writing over where in retail I never did that. The label was always done over and done correctly.

I found that sometimes the directions would be somewhat ambiguous and there would be another way to phrase it so the patient would more clearly understand, but if we were backed up and I knew that if I sent it back, it would take another week and a half, sometimes I would try to clarify it in my own handwriting, put tape over it so it would not smear if gotten wet, and let it go out. I know that I would not have done that in a retail situation.

Also, in retail you get to know your technician, you know their strengths, you know their weaknesses. In dealing with several, so many technicians as we did, we had to make no assumptions.

Senator SASSER. One final question, on this particular medication that Mrs. Owens got. Now, underneath the National Rx Services label, which appears to be typewritten just as you would get at any pharmacy, there is another label, which is the generic chemical name for Coumadin. Now, why would you have two labels there? Can you explain that?

PHARMACIST 2. Senator, we did not have that system at the plant where I was employed. However, I am familiar with prepacks and I assume that this is what that is. Oftentimes in hospitals, clinics, large facilities, prepacks will be used to facilitate faster filling. The facility gets to know pretty much, if most of the plans are a 90-day supply and the particular drug is always taken once a day, then it is pretty safe for someone at that facility to be assigned to take a huge carton or a huge bottle of that tablet or capsule and count it into units of 90 so that when those prescriptions come down the line a number of times a day, instead of having to count 90 out each time, one would reach for the prepack.

One of my assumptions would be that in this case, perhaps, the pharmacist or technician reached for the prepack and was sure that that was where the prepack of Corgard was always kept, and for some reason or another grabbed the Warfarin.

Senator SASSER. Interestingly enough, Corgard—this label says, "Corgard tabs, 80 mg, Squibb," which I assume is a brand name drug. And rather than getting the brand name hypertensive drug, she gets a generic blood thinner.

PHARMACIST 3. That was probably just a matter of location.

Senator SASSER. Right. Well, I want to express my appreciation to all three of you for coming here today and giving us the benefit of your testimony and the benefit of your experiences.

It has been very, very helpful to the Subcommittee and I think it will be helpful to us as we examine this whole problem. I want to express my appreciation to you, and I suspect before this thing is over and done with there will be tens of thousands of patients who will owe you a vote of appreciation and gratitude. Thank you very much.

We are going to have to clear the hearing room again in order that these three pharmacists and their identity can be protected, so the Subcommittee will stand in recess as the room is cleared.

[Brief recess.]

Senator SASSER. The Subcommittee will come to order.

Our next group of witnesses will consist of a panel: Mr. Lonnie Hollingsworth, the president of the National Association of Retail Druggists; Mr. Jim Vincent, the chairman of the National Association of Retail Druggists Mail Order Task Force; Mr. Jim McMahon, Oak Ridge, TN; and Mr. Del Rowe from Utah.

All of our witnesses here today are registered pharmacists, as I understand; is that correct?

Mr. ROWE. Senator, could I make one little correction?

Senator SASSER. Yes, sir.

Mr. ROWE. I am actually an attorney representing Utah Pharmaceutical Association. I am honored to be called a pharmacist, but in Utah, lawyers and pharmacists are both at opposite ends of the popularity poll, just so you know.

Senator SASSER. I understand.

All right, well Mr. Hollingsworth, we will begin with you, sir.

TESTIMONY OF LONNIE HOLLINGSWORTH, PRESIDENT, NATIONAL ASSOCIATION OF RETAIL DRUGGISTS;[1] JAMES H. McMAHON, JR., R.PH., OAK RIDGE, TN;[2] DEL BARTON ROWE, ATTORNEY AT LAW, REPRESENTING UTAH PHARMACEUTICAL ASSOCIATION;[3] AND JAMES H. VINCENT, R.PH., CHAIRMAN, NARD MAIL ORDER TASK FORCE[4]

Mr. HOLLINGSWORTH. Thank you very much, Senator.

Let me just make a couple of statements before I get into the prepared things. I am from Lubbock, Texas as you know and I have been a community pharmacist for 28 years. I presently operate two drug stores. My greatest satisfaction in pharmacy is personal interaction with my patients, very much as Mrs. Owens and her pharmacist, as you heard earlier, giving counsel, 24-hour emergency service, eyeball-to-eyeball type interaction.

The aim of my stores, L&H Drugs, is to deliver the very best and highest quality health care possible. It occurred to me as I was hearing the previous testimony that 12 to 15 prescriptions an hour is very, very busy in a community pharmacy. In my store, 20 prescriptions an hour and we are swamped. I thought that data might be good for you in view of what you heard earlier.

Also, a pharmacist as he handles certain medications, especially very dangerous ones such as Coumadin, the Lanoxin that was mentioned, things of that sort, is extra careful and you have a habit with a hands-on thing of being doubly careful about those things to prevent mistakes because you know they are life threatening.

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[1] See p. 115 for Mr. Hollingsworth's prepared statement.

[2] See p. 122 for Mr. McMahon's prepared statement.

[3] See p. 126 for Mr. Rowe's prepared statement.

[4] See p. 148 for Mr. Vincent's prepared statement.

It is also very pertinent to know that in Texas it is against the law for a technician to fill prescriptions. Only pharmacists fill prescriptions in Texas, so that if a patient in Texas was mailed a prescription from some other State, our Texas patients would not be getting the same quality service if a technician in fact filled the prescription.

Having made those points, I will, of course, present this for the record and I will try to summarize a few of the most important points for you sir.

I would like to thank you for the opportunity to be here and represent the views of the independent pharmacies of this country, some 39,000 of them—about 75,000 pharmacists work in our stores.

NARD members are primarily family businesses, as you have heard. We are pleased, as I have mentioned, to be here and we want to thank you especially, and your staff, for making the preparations for this hearing.

In response to the inquiry about mail order dispensing operations, we will try to make a few points. One is a point of general concern which I will read. The health consequences of unregulated mail order dispensing are too complex and far too numerous to enumerate entirely. In our view, the bottom line is that mail order firms cannot provide adequate health care to patients they never see. Communications between patients and pharmacists have been a vital component of pharmacy practice since its inception.

Pharmacists interact daily with patients in their stores, they monitor their patient's health status, assess their compliance with drug therapy, answer questions, make recommendations and communicate with their physicians. Patients know they can count on the pharmacist to provide expert advise on drug therapy on the spot and personally attend to the individual health care needs. This face-to-face communication is a key element in ensuring that public health will be protected.

As has to do with regulations, I mentioned, of course, that State regulations are a very pertinent thing and we go into an extensive discussion of the practice of pharmacy having long been established as a regulatory thing of the States. I made the point, of course, that if they are mailing to our State they are not getting the same quality care unless they are complying with our State laws.

We feel that the triad of the physician/patient/pharmacist relationship is very important to public health and it should not be severed. We make that point in the statement for the record.

One of our primary concerns is that both companies for-profit and non-profit have undertaken and effort to intimidate States to exempt them from such laws and regulations. They mistakenly argue that regulation of the practice of pharmacy and related concerns amount to nothing more than commodities moving commerce from one State to another.

These lobbyists even argue that mail order saves money. I really want to emphasize this point. At best, this is a close call. Recent studies indicate, especially with the elderly, costs exceed those of local pharmacies. This is in spite of reports that presently mail order firms are basically giving the drug away to build volume. In the case that was mentioned earlier, we would like to reiterate that if it were not for the stacked OPM edict that I will mention in a minute, actually the price of prescriptions in the community pharmacy has been proven by surveys to even be a bit cheaper than mail order. We would like to make that emphasis.

As it comes to Blue Cross/Blue Shield, last fall we became aware of the intent of Blue Cross/Blue Shield to radically alter the nature of the prescription drug coverage for Federal employees and retirees. Effective January 1, 1987 covered individuals would be penalized if they attempt to obtain their prescription from a pharmacy such as those we represent.

In a nutshell, a preference for a new mail order prescription drug program was established by eliminating the $250 annual deductible, but keeping this deductible for Federal employees who continued to patronize a neighborhood pharmacy. What happened is they forced the market.

The mail order dispensing is handled by subsidiaries of Medco, including National Rx Services of Tampa, FL. Anytime the Federal Government expresses a preference for competitors in our marketplace, our members are concerned. Even if the OPM had not expressed a preference for unregulated and unorthodox dispensing, we have basic concerns about the OPM approval of such preferential contracts.

They include, the contract denies Federal employees and retirees the freedom to obtain prescription drugs from the provider of their choice. It discriminates against small business competitors. By denying these consumers access to local pharmacies, they not only prevent them from utilizing a full service pharmacy, but also deny them access to price competition available in the free marketplace.

We recommend that the preference be eliminated and OPM fully explain the basis for their approval of the contract and their decision that Federal employees not have control over the quality of their pharmacy services. Certainly Federal employees should have the same quality of pharmacy services and freedom of choice guaranteed to welfare recipients under Federal law.

Additionally, if Federal employees are permitted to obtain prescriptions through the mail, we recommend that any federally approved contract provision for such services contain provisos requiring that such dispensers abide by the laws and regulations of the employee's and retiree's State of residence. In our view, this will remove such unorthodox dispensing from a twilight zone of regulations where, for various reasons, neither the home State or the host State monitors the dispensing nor provides an unmistakable forum for consumer complaints and appropriate law enforcement.

In conclusion, it is the practice of pharmacy in its full manifestation that provides the reliability and the protection the consumer has grown to and is entitled to expect. Our members interact with more than 18 million customers a day and it is those interactions which have led year in and year out for the public to select pharmacists-retail druggists as the most trusted secular profession.

To state the obvious, these essential trust relationships were not developed through the mailbox.

On behalf of the officers and Executive Committee of the NARD and our members, we thank you for the opportunity to be here and I would be glad to answer any questions, sir.

Senator **Sasser**. Thank you very much.

Do any of you other gentlemen have testimony you wish to offer today? Mr. McMahon?

Mr. McMAHON. Senator Sasser, let me first say, again, on behalf of all retail pharmacy, thank you for the opportunity under this forum to present our side of the story as pertains to the practice of pharmacy.

I am Jim McMahon, Jr., an independent pharmacist from Oak Ridge, TN. My family has practiced pharmacy in Oak Ridge for over 30 years. Oak Ridge is a Tennessee city with an unusually large population of Federal employees, many of whom are my patients. I and my colleagues are gravely concerned about the lack of adequate health care services being made available to Federal employees.

In recent months the Office of Personnel Management has instituted a mail order prescription program for Federal employees. The following are my reasons for objecting to this particular type of service:

Denying freedom of choice for the prescription drug services. This is accomplished by lack of first-dollar coverage for those not choosing mail order option;

Removing a system of checks and balances within the physician/patient/pharmacist relationship. The checks and balance system works to the patient's advantage when health care providers are local, know the patient personally, know first hand the patient's lifestyle, medical history, self-treatment tendencies and social habits;

Denying the protection afforded Tennessee citizens against non-approved product selection;

Exposing patients to the unwarranted risk of using deteriorated medications;

Encouraging the stockpiling of medications through the ordering and dispensing of large quantities of drugs with the potential for overuse and accidental poisoning of children in the home being escalated;

Denying the patient access to emergency prescription service or advice. Immediate access to health care providers is essential at times of adverse reactions or unexpected reactions to newly prescribed medications. Because of liability concerns, it is difficult for local health care providers to provide advice since they are not responsible for the total health care of the patient;

Increasing the cost of health care through over-utilization, a position that is being demonstrated, I think, by studies that are ongoing;

Reducing the availability of pharmacy services in a given area. Pharmacists cannot, either from a professional or business viewpoint, supply just the high cost, low utilization products and services which mail order operations do not provide;

Delaying initiation of therapy when the prescription does not contain all of the required information;

Circumventing the control provided by the Controlled Substances Act. In a Federal program, refill slips are issued for medications for which refills are authorized. When refill slips are lost, the patient may need only call a toll-free number to have a new slip issued. In this era of drug diversion, we are most concerned;

Encouraging unsafe requests of physicians. A Federal plan encourages patients to ask for two prescriptions of medications which must be started immediately. The local pharmacy can fill the first, the mail order the second.

Because of these identified patient concerns, I believe that the Government should review all aspects which resulted in this dramatic change in the delivery of health care services to Federal employees. For the benefit of the employee, provision of health care must be returned to the local level where the physician/patient/pharmacist relationship is maintained and where services are provided in the most cost effective manner possible.

In conclusion, I firmly believe that it is impossible for mail order pharmacies to provide the quality of service that the public deserves and demands, nor do I believe that it is fair to retail pharmacy to be left with the acute care and community responsibilities while a few enterprising businessmen skim the cream from retail pharmacy while padding their own pockets and providing inadequate pharmacy services.

I have listed several specific examples of mistakes made by mail order houses in the State of Tennessee:

Patient received Nitroglycerin in an unsealed container that had lost its potency;

Patient received Tenoretic instead of Tenormin——

Senator SASSER. What does that mean, Tenoretic instead of Tenormin?

Mr. McMAHON. Tenoretic is a product similar to Tenormin but it has an additional ingredient in it, a diuretic in addition to the beta blocker anti-hypertensive, a similar but not identical preparation.

Senator SASSER. Both of them are beta blockers, but one of them has got a diuretic in it.

Mr. McMAHON. An additional diuretic.

Senator SASSER. Yes.

Mr. McMAHON. Numerous complaints of insulin being hot.

Senator SASSER. What happens to insulin when it is hot?

Mr. McMAHON. Insulin, although it does not necessarily have to be stored under refrigeration on a continual basis—you may store it at room temperature for short periods of time—but if you were to sit it in a mailbox in 120 degree weather for any extended period of time at all, you are running a great risk of deteriorating the insulin and making it ineffective.

One patient has commented that he has stockpiled a life-time supply of insulin, and most insulin products come to us with no more than a 6-month dating period on them.

Patient received Isoptin, then started getting Callan without explanation. Now, it is the same product made by a different manufacturer, but the change in the color of the tablets causes great concern to these patients, and this happens on a consistent basis, whether it be product change from brand manufacturer to brand manufacturer, or from brand manufacturer to generic. It causes grave concerns to my patients on a continual basis.

We are averaging, at the current level, about one complaint per week in the east Tennessee area concerning mail order pharmacy.

Patients have complained that the medication was left at the doorstep and not in the mailbox;

Numerous instances of bringing bottles to the store for local pharmacists to identify the color changes; this happens frequently.

Senator SASSER. So you end up counseling your competitor's customers.

Mr. McMAHON. Absolutely. Retail pharmacy is doing all the consultation work for mail order pharmacy.

Complaints on several occasions of physicians charging $5 to $10 just to write a new prescription so they can send it off to their mail order pharmacy;

Drug interaction when a patient had a prescription filled from an emergency room at a local pharmacy that interacted with a drug filled at a mail order pharmacy, resulting in the near-death of the patient;

Mail order refused to fill an Rx due to dose question, resulting in a 4-day delay and onset of therapy;

Dispensed Disalcid instead of Sulfathalidine;

Family stockpiling medication. At least one instance of a patient dying and the patient's family approaching a local pharmacist to buy back the unused medication.

In conclusion, I am most concerned for the health and welfare of the American people receiving medications under what I have heard the conditions of testimony today, and may I go on record as saying that I am going to assume that the mail order pharmacies are going to come to me and they are going to say, McMahon, you are just up here because you are afraid of the competition and you are afraid that we are going to put you out of business.

Well, my comment to the mail order executives, is that if pharmacy is allowed to deteriorate to the level of the testimony that I have heard in this witness room today, they will not have to worry about Jim McMahon. I will go play quarterback for the Chicago Bears rather than subject myself to the practice of pharmacy at that level.

Thank you very much.

Senator SASSER. Thank you.

Do you have a statement, Mr. Rowe?

Mr. ROWE. Senator, I am going to be very brief, but I would like to just maybe ask the Senator if there are any areas—we have submitted a previous testimony to the Committee with numerous copies—but there are two or three things that have struck home here today.

Number one, we have a set of rules and regulations in the State of Utah that require compliance by our pharmacists and our citizens and unless pharmacists obey those rules and those laws, they cannot practice pharmacy in the State of Utah.

One of the principal laws we have is that there can only be one pharmacist with one technician. If you think about that, that is about as safe a combination of the use of the professional with the laymen that you can find. We understand—and from the testimony today we have heard—that pharmacists are in a ratio of whatever in the Florida example that we have heard.

We have heard even ratios up to 100 techs, or 100 people working with a pharmacist to either carry boxes from the warehouse, unfilled boxes, and put the pills on the shelf. In Utah we require that there be one technician for every pharmacist.

Now, where it sticks in our craw is AARP, for example, came in to try to put a mail order pharmacy house in Utah this past year. They ran into that law and they went to the Governor and bawled and they went to the newspapers and cried, and they went to the television stations and chewed out the Governor and chewed out his administration and the Pharmacy Board because they would not grant them a license to set up a mail order house.

They wanted to come in with a minimum of 10 technicians per pharmacist and as much as 50 technicians per pharmacist. Our law would not permit that. Yet, they said the Governor was unfair. They said his administration was incompetent, and they embarrassed him. But our law is very strict for the safety of our people.

I have five cases that I have given in my presentation. I will just mention one. As Jim McMahon—and in tribute to him and the real Jim McMahon from Brigham Young University from our State—I might mention that at Brigham Young University one of our top professor's wife was what we call a "brittle" diabetic. A brittle diabetic, as Mr. McMahon will tell us, is an individual who has a severe diabetes problem.

In this case, she required an order of insulin to be sent consistently, took the insulin, and in this particular case Utah's temperature, for example, ranges from 130 degrees, in some cases, down to 40 below zero. If you can imagine insulin being in somebody's mail box out in their front yard in those various kinds of temperatures and sitting there until the individual uses the insulin—in this case she used the insulin and it had been out in the heat, was no good, and she went into a diabetic coma.

And here is the other point I want to make today. We have got an imposition problem here. It is an imposition for mail order houses to put the burden of counseling their people on the shoulders of our pharmacists, and that is what is happening.

I am going to propose legislation that says we bill these mail order houses for every phone call we get for eating up our time, because we do not want to have to give counseling. If you think of the legal liability for us to give counseling for mail order houses' drugs, that is an imposition that we do not want to share. But to save lives and to save health and well being of people, we will do that and we will suffer the consequences of lawsuits from individuals that may receive a danger.

Now, let me just give you an example of this counseling problem. Here is the Federal employees' Blue Cross/Blue Shield handout. In Utah it went to 35,000 Federal employees. Here is the announced mail order drug program. On the back cover is the telephone number that you use. The telephone number is 1-800-554-6800. I have dialed that number, not only from Utah, but today from Senator Orin Hatch's office, our Senator, and the phone number is disconnected.

Now, I would ask Senator Sasser or his staff to call that number today or tomorrow to see what kind of counseling you could get if you were on a mail order program and the number is disconnected. It says, ask for Operator 22, but when I got the recording, I could not ask for Operator 22 because it was disconnected.

Finally, it just seems to us out in the States that what we want them to do is comply with our laws like we have to. The Attorney

General of the State of Utah just this last year issued an opinion on the Utah statute. We have a Utah statute that says, you do not advertise for the selling of prescription drugs in Utah unless you are a licensed pharmacist.

I have here all of the advertisements sent into the State of Utah, including this book of 141 pages by the Association of Retired People. And this is interesting, they have two pages actually of prescription drugs and 141 pages of non-prescription drugs, and by the way, they just happen to get a $6.5 million Federal subsidy—the AARP does—for their mailings.

I am not saying they mailed this catalog out free, but all the mailings that tell their people to order through the AARP pharmacy services, all of those mailings they mail out telling them to but it through this stuff, if you look at the competition to our people from the AARP catalogue, probably as high as 400 items in this catalogue can be bought, but they get a $6.5 million take or help and we do not get that as Utah pharmacists.

In conclusion, back to the Attorney General's opinion, it says you do not advertise unless you are a retail pharmacist in Utah and you are licensed. They have now sent out cease-and-desist letters to Medco, to the other organizations we have heard of today to tell them to comply with Utah law or they are going to be criminally prosecuted, and that prosecution means that for every piece of mail that comes into the State of Utah, it is a Class A misdemeanor that carries a fine of $2,000 or a year in jail.

So what we want them to do, if they want to come into Utah, we welcome them. We would love to have them. If they want to compete and provide the quality of pharmacy that we have going there, we will compete with them. But we think it is unfair that they get a Federal subsidy, they do not comply with our law, and they do not give the protection and the safety to our people.

Senator, thank you.

Senator SASSER. Thank you.

Mr. Vincent, do you have a statement you wish to make today?

Mr. VINCENT. Yes, Senator, thank you. My prepared statement is here for the record. I have just a very brief two or three remarks I would like to make today, which would be contingent on some of the things we have heard, I think.

I have been a practicing pharmacist for 36 years and an owner of my own pharmacy for the last 29 years. When I became a pharmacist, I took an oath to protect the public health, safety and welfare to the best of my ability.

My store is an independent store in rural Colorado. Ten years ago I became aware of mail order prescriptions being ordered and received by some former customers and friends. This awareness was pointed up by those friends bringing prescription medications to my pharmacy and showing them to me. They asked questions about different colors and sizes they were unfamiliar with which were being sent by mail order outfits because they were not the same as those they had previously received from my pharmacy. The question these friends asked was and is today, is this the same thing, the same medication that I used to get from you and do they treat the same thing that I am bothered with?

Customers commonly believe that their pharmacist can identify all medications. And they can, if that pharmacist dispenses, and if not, when it carries the companies identifying trademark on the medication or on the label.

Often, I could not answer the questions. I could not identify many of the medications because they had no familiar markings, colors or sizes. However, privately, genuine concern arose in my mind—what is happening to the prescription delivery system with the advent of mail order?

In practicality, we have a very closely woven, nearly perfect fabric which now has a gaping hole in it. Colorado, as in many States, has very rigid pharmacy laws and regulations which protect the public health, safety and welfare. What laws do some far away States have which will equally protect the citizens of the State of Colorado? No answer to that question existed in the many times the question has posed itself to me, nor does that answer exist today.

This led me to believe that mail order pharmacy on a national basis is pharmacy practiced at its lowest common denominator. Pharmacy in its highest calling is a hands-on practice between the physician/pharmacist/patient triad. Exit the pharmacist from the triad and the consumer is at great risk.

For my own State, to fortify what was said here at the table just now, in my own State we have a strong requirement governing the use of ancillary or non-pharmacy personnel in the prescription area. It is called the one-on-one regulation, the same as Utah.

Because Colorado recognizes very limited duties by technicians in delivering medications may be efficient, it is also fraught with danger. Only one technician may work behind the counter, if fully supervised by one pharmacist, no more. I understand many States do not have the rule one-on-one. I have heard, but cannot confirm, high volume mail order outfits have as many as 16 non-pharmacy technicians supervised by one pharmacist. If that is so, what indeed may be happening?

How comprehensive are inspections made by various States into mail order pharmacies? I do not know. In my State inspections are intense, particular and thorough. The consumer may have total peace of mind about the quality of pharmacy practiced in Colorado.

Thank you very much, Senator.

Senator **Sasser**. Thank you very much, gentlemen. The hour is late and we have another witness to follow, but I do want to ask one or two questions.

I will ask my good friend from Oak Ridge, TN, how well do you think physicians inform their patients about the medications that they prescribe for them? I say that in the context of, do you find that when patients come to you, are they asking you about the drug or medication that has been prescribed by the physician? Or do they seem fully informed already and simply ask you to perform the mechanical role of filling them?

Mr. **McMahon**. In my local community, physicians by and large do a very good job of informing their patients of any adverse consequences that they might see as the result of taking their medication. However, we are on a continual basis asked by our consumers, on a daily basis, to back-up the information, either information that they may have misunderstood from the physician, or to gain further information themselves as to the side effects of the drugs that they are taking.

This is becoming an increasingly larger proportion of the practice of pharmacy. We are talking about pharmacist-patient consultation, and we are doing more and more of it each year.

Senator SASSER. Do you find that the pharmacists themselves are counseling with the physicians at all? That is, are the pharmacists contacting the physicians about medication that might be prescribed, or vice versa, for particular patients as to how the medication might be helping or failing to help the patient? Is there any interaction between the pharmacist and the physician?

Mr. MCMAHON. In my community, there is considerable interaction. And again, in the smaller communities the pharmacists and physicians have a tendency to know each other on a personal basis as well as a professional basis, so we have quite a bit of interaction between pharmacists and physicians in my community.

I might also add, Senator, that in the age of computerization every store in the city of Oak Ridge is computerized now, which allows pharmacies to track all drugs that are dispensed to patients on their computer screens and we are constantly aware of and watching for drug interactions on medications that were dispensed but from different physicians, or versus over-the-counter medications and prescription drugs they are taking.

So all pharmacists now have become actively involved in communicating with the patient concerning these type of things.

Senator SASSER. Now, one of the things that concerns me, and the principal reason, I suppose for these hearings here today is the question of what type of supervision or regulation mail order firms are presently subjected to.

In other words, the Federal Food and Drug Administration goes to great length—some say it goes to excessive lengths on occasion—to guarantee the safety and soundness of a drug before it is put on the market; also to try to guarantee the wholesomeness and safety of the drug in the process of manufacture.

Now, what type of regulation are you pharmacists subject to in your States? Mr. Rowe, you might be a good one to answer that since that might fall right in your category as a lawyer.

Mr. ROWE. Well, the number one regulation or rule that I have already mentioned is the one-on-one tech to pharmacist ratio.

Senator SASSER. Now, this is in the State of Utah.

Mr. ROWE. It is in the State of Utah. Are you talking about nationally?

Senator SASSER. Well, if you can address the question nationally.

Mr. ROWE. Well, as far as we know, the control of those pharmacists, for example, that work in the out-of-State pharmacy—we have no in-State mail order pharmacy houses in Utah—but the out-of-State pharmacy house, those pharmacists are controlled by those States. Those States could have no laws on pharmacists or no laws on techs and they could not control them and they could not do anything to enforce good procedure.

So I guess what we are stuck with out in Utah, we have got to depend on Pennsylvania to investigate and to take care of and to administer the issuance of drugs out of a Pennsylvania house to our Utah people. Now, we are not that confident that Pennsylvania is going to comply with the strictness of the Utah law. I doubt Pennsylvania could comply, as far as I know, with the strictness of probably the laws in half the States.

Senator SASSER. Well, my principal concern is the question of complaints. Now, let's take the States that we are familiar with here—Utah, Texas, Tennessee, and Colorado. Now, an in-State or a resident of those particular States, I assume if they have got a problem with a pharmacy or a pharmacist, they can complain to the local Pharmacy Board; is that an accurate statement?

Mr. MCMAHON. With State Boards.

Mr. HOLLINGSWORTH. State Board of Pharmacy.

Senator SASSER. Just how effective—and it may vary from State to State, I assume it does—just how effective are these State Pharmacy Boards in responding to the complaints of patients or consumers?

Mr. ROWE. Senator, I could address that quickly. In Utah there is a staff of investigators that work with the Pharmacy Board. Now, we are talking about a Pharmacy Board appointed by the Governor of the State of Utah to serve as a five-member board to govern the affairs of pharmacy. They work within the Utah Department of Business Regulations.

That department has a staff of investigators to investigate every complaint against pharmacists in the State of Utah. I believe that is the way it is in most States.

Senator SASSER. How about Tennessee? I ought to know about my own State, but I am embarrassed to say I do not.

Mr. MCMAHON. Senator, let me thank you for asking this particular question, because this is one of the primary concerns that local retail pharmacists have concerning mail order prescription pharmacies. They are not subjected to the same regulations, the same inspections and the same guidelines. They are not playing on the same football field.

In the State of Tennessee, our substitution law is very stringent. It is actively enforced by the state of pharmacy. We have State Board of Pharmacy inspections in our area a minimum of once a year. We would like to see some type of form developed whereby the mail order pharmacies may be inspected by individual State Boards of Pharmacy and if found——

Senator SASSER. In the particular States that they operate?

Mr. MCMAHON. In the particular States that they operate. In other words, the State of Tennessee will need to go down to the State of Florida and inspect the Florida mail order houses to ensure that they are abiding by the same State laws that we must abide by. Just let us play on the same level playing field is what we are asking.

Senator SASSER. Well, now, I am concerned about a situation like Mrs. Owens who testified here today. Now, instead of her medication to relieve her hypertension, she gets Coumadin blood thinner. Now, where does she turn? In other words, I judge that the State Pharmacy Board, if the mail order firm sent this in across State lines, has no jurisdiction over the mail order firm; is that correct?

Mr. HOLLINGSWORTH. I believe that is what they testified in both the letter and here testimony, yes.

Senator SASSER. All right. Now, the Food and Drug Administration has no jurisdiction because their jurisdiction does not extend to retailers. So who does have the responsibility for regulating the mail order firm?

In other words, it appears to me to be a contradiction to have the Food and Drug Administration regulating the manufacture and production of the drug and the States regulating the retail seller, the pharmacy, but nobody regulating the retail seller that sells through the mail.

Mr. HOLLINGSWORTH. You make a very good point, Senator, an excellent point.

Mr. ROWE. And Senator, the only control that I know of are malpractice suits by lawyers.

Senator SASSER. Well, I was just thinking about that. Strange that would occur to you, Mr. Rowe.

Mr. ROWE. I do not know where I got that, Senator, but it just came.

Senator SASSER. But it would appear to me that the mail order firms might want some regulation for their own protection. I think once the trial lawyers get on to what is happening here it is going to be, "Katy, bar the door," as far as the mail order firms are concerned, if the testimony we hear today is typical of what is occurring in the industry. I have no way of knowing if it is or not.

Mr. ROWE. Senator, could I mention one incident. I am in communication with the legal counsel for the California Pharmaceutical Association, and may I say that in his instance, an individual representing the Food and Drug Administration—I believe it was, and I am not sure—but nevertheless, it was a Federal individual who came to their State Board of Pharmacy and said, you try and control mail order pharmacy as a State and we will criminally prosecute you for violation of Federal laws because we believe that that is a Federal jurisdiction.

I appreciate your comment today because you have said—and it is true—there is no control over these out-of-State mail order houses.

Senator SASSER. Well, I was posing the question, is there some control?

Mr. ROWE. Lawsuits are the only things that I can think of from the safety standpoint. Otherwise, there is no Federal Board, unless the State Board of Pharmacy in these States where the mail order houses are, want to bring us in to let us put a person on their Board, I see no control here.

Mr. VINCENT. Senator, what would the jurisdiction be on such a lawsuit? Where would the jurisdiction be? I cannot even perceive that.

Mr. MCMAHON. Senator, I would like to urge Federal legislation that would require mail order pharmacies to be subjected to the regulations of each and every State in which they mail prescriptions to.

Senator SASSER. Well, gentlemen, thank you very much for appearing here today and giving us the benefit of your testimony. We appreciate it.

Mr. VINCENT. Thank you, sir.

Mr. HOLLINGSWORTH. Thank you.

Mr. McMahon. Thank you very much.

Mr. Rowe. Thank you.

Senator Sasser. Our next panel will consist of representatives of the Medco Containment Services Corporation, the parent company of National Rx Services. This panel will consist of Mr. Martin Wygod, the chairman and chief executive officer of Medco Containment Services, Inc.; Mr. Robert Marotta, senior regulatory counsel; Mr. Fred Klein, vice president for professional services; and Mr. Paul Suthern, vice president for operations.

Gentlemen, I apologize for the lateness of the hour, but at your request we are taking up your testimony today rather than tomorrow as originally scheduled. We are delighted to have you here and look forward to hearing your statements.

I assume, Mr. Wygod, you will wish to be the spokesman?

TESTIMONY OF MARTIN J. WYGOD, CHAIRMAN OF THE BOARD AND CHIEF EXECUTIVE OFFICER, MEDCO CONTAINMENT SERVICES, INC.,[1] ACCOMPANIED BY ROBERT MAROTTA, SENIOR REGULATORY COUNSEL, FRED KLEIN, VICE PRESIDENT FOR PROFESSIONAL SERVICES, AND PAUL SUTHERN, VICE PRESIDENT FOR OPERATIONS

Mr. Wygod. Yes, Mr. Chairman. Would you prefer that we start tomorrow morning?

Senator Sasser. Well, I think we are all here and ready to go today, so we will go forward with it.

Mr. Wygod. Mr. Chairman, I appreciate the opportunity to testify today. I have never testified before Congress and I do not pretend to be an expert in your procedures, but I must express my disappointment about the way today's hearing has been structured.

I am concerned that the procedure of allowing witnesses to remain anonymous prevents testing of their veracity by the public and the press. Because there is no public knowledge of who these people are, we have no idea what their motives may be. Are they disgruntled former employees? Are they now affiliated with Medco's competitors in the retail market? Do they have a financial interest in undermining Medco's reputation? The truth is, procedural fairness would normally allow the public or the press to raise information which would test the veracity of such witnesses. Unfortunately, that opportunity has been lost.

A more important point, though, Mr. Chairman, is that regardless of the motives of these witnesses in concealing their identities, there are many reputable authorities who would be willing to openly discuss the safety and soundness of the mail service pharmacy. This would include, for example, the AARP, which has provided mail order prescription services to its hundreds of thousands of members since 1959; any member of the Florida Board of Pharmacy, which regulates the largest mail service pharmacy program for Federal employees in the country; any one of the hundreds of companies who use mail service pharmacy, ranging from General Motors to the Bell Telephone companies; any member of the dozens of unions which use mail service pharmacy, including the International Ladies Garment Workers Union, the United Auto Workers and the American Federation of State, County and Municipal Employees; any representative of the dozens of public employee programs, such as those in Florida and New York; any official of benefit programs, such as the Special Agents Mutual Benefit Association, which serves employees of the FBI and the Drug Enforcement Agency; and any trustee of a major public retirement program, such as those in Texas and Ohio. We would suggest that any review of mail order prescription services should include testimony from such authoritative, reputable witnesses.

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[1] See p. — for Mr. Wygod's prepared statement.

We have heard from a customer and a pharmacist about one dispensing error made 6 months ago. We have acknowledged this mistake. The matter was thoroughly aired before the Florida Board of Pharmacy on referral from Virginia and corrective action was taken. There was nothing about this error peculiar to mail service. The error could have occurred in any retail pharmacy setting as well, and Medco's handling of this error clearly demonstrates that NARD's contention that Medco hides its errors is simply not true.

We have heard from our principal competitors, the retail druggists, and their trade association. We have certainly heard from them before. In recent years they have launched an all out campaign against mail service pharmacy with only one motive—to restrain competition. They have been virtually to every State legislature and regulatory agency and many of our major customers attempting to discredit mail order prescription services. Having been unsuccessful in these attempts, they have now brought their road show to the United States Senate and this Subcommittee.

Their intent today is to interfere with our relationship with our Federal customers and to create a one-sided record here today to use against Medco and mail service pharmacy in general in other forums.

Mr. Chairman, having aired my concerns, let me now turn to the subject at hand, safety and soundness of mail service pharmacy. I must tell you that I was very frustrated listening to the various allegations thrown about today. All I can try to do in my brief time is to assure you that there is another side of the story. I have tried to outline it in my written statement, and I have also attached an appendix to the written statement which answers in detail each question of your letter of July 29, 1987, inviting us to testify at today's hearing.

We fully intend to supplement the testimony given here today with additional information from our customers and regulatory bodies and any other information you or other members of the Subcommittee request. I respectfully request that the statement and the appendix and the exhibits be included in the record.

Mr. Chairman, it is important to note that mail service pharmacy is not a new or even novel development in the practice of pharmacy. The Veterans' Administration initiated a program as early as 1946 and the American Association of Retired Persons has offered a similar program to its members since 1959. The rapid growth of mail service pharmacy and participation by others has been due to a variety of factors, not the least of which is consumer demand for a prescription drug system that offers cost savings, convenience and safety.

Proof of such public demand is that mail service sales of prescription drugs has grown 50 percent per year since 1981, from less than $100 million in 1981 to in excess of $750 million in 1986. It is estimated that mail service sales will increase 30 percent per year through 1991, reaching $2.8 billion, or 10 percent of the total U.S. prescription drug market.

Medco's customer base has grown since 1983 to 500 institutional clients today. During the 9 months ended March 31, 1987, sales were $188 million compared to $95 million for the 9 months ended March 31, 1986, representing a 100 percent increase.

The dynamics of such growth speak well of the concept and are based, in substantial part, not only upon the well-recognized cost savings, but also the proven safety and soundness which underlies this type of pharmacy practice. Safety is a necessary component of any consumer business, and the fact is that the safety record of mail service pharmacies far exceeds that of retail pharmacy. It is critical that our consumers be satisfied with our products and service, because mail service pharmacy comes under much greater regulatory scrutiny than the retail pharmacy.

Mr. Chairman, let me cite two independent studies that verify the safety and soundness of mail service pharmacies. A July 1987 study prepared by Mercer-Meidinger-Hansen, a nationally requested health care consultant, at the request of the Mountain Bell Company audited a Medco Pharmacy.

Their conclusion was: "We feel Mountain Bell's current program with National Pharmacies, Inc., is meeting the needs of its employees and dependents. National Rx Services appears to be using sound medical guidelines and numerous safety and quality checks to assure Mountain Bell of a quality program."

A 1986 study by the Center for Pharmacy Management and Research of the University of Tennessee College of Pharmacy stated: "The overall rating of the service was excellent or good. In fact, the rating for mail order services was slightly better than the rating for community pharmacy services."

Mr. Chairman, we are proud of our operation and invite you or any members of your Subcommittee or staff to inspect any of our facilities at any time. Alternatively, if you would like, we invite you to send investigators from the General Accounting Office, the Office of Technology Assessment, a private auditor, or any persons you would designate.

We welcome you and we would only ask that for reasons of comparison you do the same with a representative sample of retail drug stores. Such a comparative study would not only be useful for the Subcommittee's purposes, but would also demonstrate why we at Medco have the confidence to stand on our record for safety and soundness.

Mr. Chairman, in closing we encourage you and the members of the Subcommittee to weigh carefully what you have heard today and who was saying it. We urge you to move cautiously and avoid any actions that could unnecessarily stifle the growth of this important health care service.

Mail service pharmacy is improving the lives of American citizens. It is also helping make safe health care more accessible and cost-effective. We are proud of the progress that the mail service industry has made, and I am proud of the part we have played in that progress.

Mr. Chairman, I appreciate the courtesy extended by you and your staff and we will be pleased to try to answer any of your questions.

Before that, though, I would just like to make a few things explicitly clear. We have pharmacies in six States. In New York, in Florida, and in Nevada we do not use technicians, we just use pharmacists. The law is written that way, and we are audited on a very regular basis.

The second point is, I heard earlier in this session that someone has died from getting a mail service prescription. Were they talking about Medco Containment Services or National Rx Services? If they were, we do not know anything about it.

We know of 13 claims made against us of the last 15 million prescriptions that we have filled, and there is nothing in there that ever talks about anyone that has died subsequent to receiving any prescription from us.

Thank you.

Senator SASSER. Do any of your associates wish to make a statement, Mr. Wygod?

Mr. WYGOD. No, I think we will open it up to your questions, sir.

Senator SASSER. All right. Thank you.

I might say to you that the rules of evidence as used in legal proceedings are not in force before a Congressional Committee, as I am sure you are aware of. But in an effort to be fair, the AARP and the Veterans' Administration will both testify tomorrow. I assume they will testify in defense of their mail order operations, just as you have done today. So we are attempting to get a balanced view of the situation, doing our best to do that.

Now, let me ask you this question. You heard a moment ago my concerns about what type of regulation or supervision that mail order firms might be subject to. Would you, for the purposes of the record, describe what supervision of lack thereof your firm is subject to.

Mr. WYGOD. Would you allow me to have Mr. Marotta, our Regulatory Counsel, answer that from a regulatory point of view, and then our VP of Operations from an operational point of view?

Senator SASSER. I think we are most concerned here about regulations from an operational point of view, because that seems to be principally where the complaints against mail order firms originate. We assume that the Food and Drug Administration has responsibility for guaranteeing the purity and wholesomeness of the quality of the product that is distributed, and they have a reputation for doing their job quite well.

So why do not we talk about the operational aspects.

Mr. SUTHERN. Very good. Senator, one of the things that I have heard today is that National Rx Services employs a quota system. Let me for the record state that we do not employ a quota system. We have, in essence, a bonus system that is in effect in our New Jersey and in our two Ohio facilities that is based on the number of prescriptions that they check per week.

Senator SASSER. How much is the bonus per prescription.

Mr. SUTHERN. It is 15 cents per prescription over a rate set, which is different between the three pharmacies that employ them.

Senator SASSER. Well, what is the rate? How many prescriptions do they have to fill before they get the 15-cent bonus?

Mr. SUTHERN. On a weekly basis, for example, in Ohio, 2,130 prescriptions.

Senator SASSER. So that is precisely what these witnesses testified to, is it not?

Mr. SUTHERN. Right. But only 60 percent of the pharmacists in question ever earn a bonus, and most of them—the bonus system was established as an overtime factor. We do not pay our pharmacists time and a half over 40 hours in Ohio, and in lieu of that, to encourage overtime, we decided to implement this bonus system about 2 years ago. Over the last 90 days, of the 60 percent of the pharmacists that received bonuses, 57 percent of the bonus pay was due to overtime and not based on a productivity rate that was in excess of the 53 an hour, or whatever it might have been.

Senator SASSER. In other words, they are working overtime to access the 15-cent per prescription rate over and above the minimum that is set for them. So you have got a minimum. They have got to fill 2,130 prescriptions; is that not right?

Mr. SUTHERN. They do not have to fill prescriptions. They have to check.

Senator SASSER. Well, if they are going to get a bonus, they have got to fill 2,130, do they not?

Mr. WYGOD. They have to check, not fill.

Mr. SUTHERN. They have to check 2,130 prescriptions.

Senator SASSER. All right. So, if they want to get compensation in excess of their regular pay, they have to work overtime to make the 15 cents per prescription.

Mr. SUTHERN. That is used as an overtime factor.

Senator SASSER. What happens to a pharmacist who consistently fails to meet the 2,130 prescriptions per week?

Mr. WYGOD. If he is substantially below that, we will counsel him and we will try to find out what is preventing his productivity from being higher. It is not a quota system. We do not discharge anyone because they produce a lower volume of prescriptions. It is an optional bonus system for pharmacists that are able to check, competently and carefully, a larger number of prescriptions.

Senator SASSER. Well now, if they are going to fill 2,130 prescriptions a week——

Mr. SUTHERN. Senator, can I just——

Senator SASSER. Well, let me finish.

Mr. SUTHERN. OK.

Senator SASSER. If they are going to fill that number and they are working 40 hours a week, if my arithmetic is correct, that is 54 prescriptions per hour, which is precisely what these witnesses testified here earlier today; is not that correct?

Mr. SUTHERN. Senator, only 47 percent of the time, based on the three pharmacies that have a bonus system, was spent on the bonus system. So the other 53 percent of their time is spent on professional aspects such as doctor calls, utilization reviews, customer service work, talking to clients, screening original prescriptions that come in through the mail. What National Rx Services does is give them credit for time off the line. We do not want or expect our pharmacists to work more than 50 percent of the week on checking prescriptions.

Senator SASSER. So then, you are saying that you disagree with the statements made by these three witnesses that they began by working 50 percent of their time checking prescriptions but later on, as the workload increased, they worked 100 percent of the time checking prescriptions? So you disagree with that?

Mr. SUTHERN. The last 90 days of the two pharmacies, they range from 45 to 55 percent off-line. I do not know which pharmacy we are referring to with these witnesses.

Senator SASSER. How many pharmacies does Medco operate?

Mr. WYGOD. Eight.

Senator SASSER. What States are they in?

Mr. WYGOD. New Jersey, New York, Florida, two in Ohio, two in California, and one in Nevada.

Senator SASSER. Now, do you have this bonus system in all of the plants?

Mr. SUTHERN. No, sir.

Mr. WYGOD. No, we do not.

Senator SASSER. Just in three of them?

Mr. SUTHERN. Yes, sir.

Mr. WYGOD. Yes, sir.

Senator SASSER. Why do you have it in just three of the plants?

Mr. SUTHERN. With the new compensation factor, we thought it was a better recruiting tool to give time and a half with our pharmacies. It was easier to explain to them.

Senator SASSER. But you just use it in three and it is not systemwide?

Mr. SUTHERN. No, sir.

Senator SASSER. And you are telling us you use it as a recruiting tool?

Mr. SUTHERN. The time and a half, now, yes, sir.

Senator SASSER. In lieu of time and a half you give them 15 cents per prescription over a certain number.

Mr. SUTHERN. Right, in the three pharmacies that have the bonus system.

Senator SASSER. All right. Now, with regard to your pharmacies, what is the ratio of technicians to pharmacists? Did we hear a correct story here about technicians filling the prescription and the prescription being checked by pharmacists?

Mr. WYGOD. On the sheets that we have submitted to you—Paul, why don't you read the number of technicians per pharmacist per location. Perhaps that would answer it.

Mr. SUTHERN. In our New Jersey facility—and this will include the number of staff pharmacists and supervisory registered pharmacists—we have 52 pharmacists and we have 53 technicians; in Albany, NY, at the present time we have 13 registered pharmacists and no technicians; in our Columbus, OH——

Senator SASSER. How many technicians in Albany?

Mr. SUTHERN. None. In our Columbus, OH, facility, the first one, we have 32 registered pharmacists and 32 technicians; in our second facility, we have 46 registered pharmacists and 50 technicians; in Nevada, we have 36 registered pharmacists and no technicians; and in Florida——

Senator SASSER. Now, is that pursuant to State law?

Mr. SUTHERN. Yes. In Nevada.

Senator SASSER. In other words, whether you have technicians that fill the prescription or pharmacists who fill the prescriptions, that is in compliance with State law in that State?

Mr. SUTHERN. Yes, sir.

Senator SASSER. Where they are located. In other words, in the States where you have no technicians filling prescriptions, that is pursuant to State law; is that a correct statement?

Mr. WYGOD. Yes.

Senator SASSER. And in the States where you have a combination of pharmacists and technicians, that is because that is allowable under State law in this particular State?

Mr. WYGOD. That is correct.

Mr. SUTHERN. In our Tampa facility, we have 98 registered pharmacists and we do employ 9 technicians there, not in the dispensing process but to work our warehouse.

Senator SASSER. Where is this?

Mr. WYGOD. Tampa.

Mr. SUTHERN. Tampa, FL, sir.

Senator SASSER. How many?

Mr. SUTHERN. Ninety-eight registered pharmacists, and we do employ nine technicians, but they do not work in the dispensing process; they work in the warehouse.

Mr. WYGOD. And in Tampa you would be allowed, for certain functions such as screening, to use technicians, but as an experiment we wanted to see the difference of what would take place with all pharmacists compared to a facility that was mixed 50 percent with pharmacists, 50 percent with technicians.

Senator SASSER. Now, you state that you do not have a quota system; that is your testimony here today.

Mr. SUTHERN. Yes, sir.

Senator SASSER. Do you maintain records of how many prescriptions are filled by your pharmacy technicians or pharmacists on an average basis?

Mr. SUTHERN. In the three pharmacies that do not employ a bonus system, we have no productivity records. The three pharmacies that do employ the bonus system, we do have record keeping for pharmacists for calculations of the bonus system, and we do keep certain records on our technicians on filling.

Senator SASSER. Now, what has been the nature of your business growth over the last 3 years. How much has your business increased? Substantially?

Mr. WYGOD. Yes, sir.

Senator SASSER. In percentage growth over 3 years, what would that be from beginning to end?

Mr. WYGOD. We were running at a rate of approximately $25 million a year 3 years ago and right now we are running at an annualized rate very close to $400 million.

Senator SASSER. So you have had—about a 1000-percent increase, at least in the volume?

Mr. **Wygod**. Yes, I believe we are one of the fastest growing companies from internal growth in the United States today.

Senator **Sasser**. Right. So how do you get enough pharmacists and/or technicians to keep pace with the growth of your business?

Mr. **Wygod**. Paul?

Mr. **Suthern**. The company has decided to keep these facilities regional and on the rather small side. We go into an area and, as in Tampa, we were able to hire 90 registered pharmacists in a little less than a month. We were a little competitive on the wage scale, but because we offer a complete professional experience such as they can practice their pharmacy, we had no trouble recruiting in that particular area. Nor have we ever had a problem recruiting in Nevada or Albany or any other facility.

We usually obtain pharmacists with between 5 and 10 years or retail experience who want to work for us because they just do not want to work out in the retail environment. They talk more of burn-out in those situations where they work 12-hour days, trying to handle many functions at one time, where we allow them, under our operation, to concentrate on one aspect of the dispensing process at one time, with little interruptions either from customers or phones or whatever it might be.

Mr. **Wygod**. There is a tremendous number of highly qualified pharmacists that are very anxious to go to work for a facility such as ours. If you could visit one of them, I think you would understand it.

Senator **Sasser**. Now, what about the procedures in the new plants. Are you going to locate those in States where laws permit technicians as opposed to just pharmacists-only States?

Mr. **Wygod**. There is no correlation. If you look at our six facilities, Senator, you will see that we have located in States where they do not allow any technicians—any. So the statement that we heard earlier that we do not go into a State because we have to have one technician to one pharmacist—as far as Medco is concerned, it does not make any sense to us.

We train our pharmacists for close to 90 days. In a new facility when they open up, we bring in pharmacists from other locations to help train them. We bring in outside organizations to help train them. We have different types of study programs so we are sensitive to the elderly when they are under stress so we can communicate with them properly on the phones.

We go to tremendous lengths to try to deliver the highest quality of service to the individuals, because the growth of our company is totally based upon the satisfactory service that the individuals are receiving. Every one of our major accounts that we have had for a period of years has grown each year. More and more people have used us in that same plan. The ILG started using this company 12 years ago. They have had millions and millions of prescriptions filled and they have never had a quality problem.

We have the Ohio retirement systems that have grown at a compounded rate of close to 20 percent per year. The reason it grows so rapidly is word of mouth, the quality of the service.

Senator **Sasser**. Well now, is it quality of service or price, Mr. Wygod, that is making your service grow so fast? It is difficult for me to believe that the quality of a mail order service would cause it to grow that rapidly. The whole business of mail order drugs is price driven, is it not?

Mr. WYGOD. I would have to disagree with you, sir. These are funded plans. The individuals usually are not paying for these drugs. They are usually paying a co-pay of a dollar, zero, $2 or $5. We only service funded plans—the insurance company or the employer or the union or the State employee plan pays for it. The individual does not pay for it.

Senator SASSER. But, if I could interrupt you just a moment though, the plan would contract with your company because it is cheaper, is it not? There is nothing wrong with that, but as I understand it, it is the effort to contain costs that really is the driving thrust behind the growth of the mail order drug business, whether it is your firm or others. Do you disagree with that?

Mr. WYGOD. Yes.

Senator SASSER. And you think it is a question of the quality of the service that mail order offers, that is the driving force behind the phenomenal growth in the mail order drug business?

Mr. WYGOD. I believe that if the quality was not there, the individuals would not use the plan. The savings go to the funded plan. Mail service is a more efficient delivery system than retail. We believe it is. But for the individual to use it, this is an optional service. He has the right to use us or the retail pharmacy. He makes that decision.

Senator SASSER. Now, that is not true in all plans, as I understand it.

Mr. WYGOD. It is in 99 percent of our business.

Senator SASSER. Do you mean that your customers have the option of going to the local drugstore——

Mr. WYGOD. Exactly.

Senator SASSER [continuing]. Or ordering their products through——

Mr. WYGOD. Exactly.

Senator SASSER. In every plan that comes into your system?

Mr. WYGOD. Every single plan. We have 12 million people covered. The only reason that we are doing 225,000 prescriptions per week is the other 80 percent of the people are getting their drugs through the retail environment. This is an alternative delivery system.

Senator SASSER. Well, that is news to me. But that is what these hearings are for, I suppose, to get the facts and it is a learning process.

Now, you do maintain records for all of your pharmacists and technicians—did you say you did not maintain records as to how many prescriptions they fill?

Mr. SUTHERN. We maintain records for pharmacists in the three pharmacies that have a bonus system. In the three pharmacies that do not have a bonus system, we do not have any productivity records. On technicians, we do have productivity records for certain of their aspects in the Ohio and New Jersey pharmacies.

Senator SASSER. How many pharmacists do you employ systemwide?

Mr. SUTHERN. Senator, I believe that number, with supervisors, is 282 as of July 31st.

Senator SASSER. And what proportions of pharmacists do you have that resign voluntarily from your operation and what proportion are fired?

Mr. SUTHERN. I do not have that information with me, Senator. I can tell you that it is very low.

Senator SASSER. Would you be agreeable to furnishing that information for the record?

Mr. SUTHERN. No problem at all.

[The information furnished follows:]

Twenty-five since January 1, 1987. The reasons for pharmacists leaving the employ of Medco are varied, to include raising children, change in career, a death, and so on.

Senator SASSER. Well, in general, if you will, describe the safety and soundness standards that you follow in dispensing a prescription drug. Now, when the prescription comes into your firm, as I understand it, it is read by someone there who apparently is designated as the screener; is that correct?

Mr. SUTHERN. That is correct, Senator.

Senator SASSER. That person then determines the type of drug, the level of dosage, and puts that on to an order form, I assume? Just describe the way the system would operate for us.

Mr. SUTHERN. If I may take the Tampa facility, an order will come in and will go to a registered pharmacist to screen the prescription. By that, the registered pharmacist will check that prescription to ensure that it is a legal prescription—that it is dated, the doctor has signed it, the directions are there.

Senator SASSER. All right. You have taken the Tampa plant. How about your other locations. In how many of your locations does the prescription go to a pharmacist first for screening?

Mr. SUTHERN. In screening, in Albany and in Nevada it is done by registered pharmacists.

Senator SASSER. Is that a result of State law or is that a result of company policy?

Mr. SUTHERN. In Nevada it is State law. In Albany—Bob, is that——

Mr. MAROTTA. I think, Senator, it is a combination of both. At the minimum it is required by State law, but the company is moving to a total pharmacy operation.

Senator SASSER. Well, why do you not have pharmacists reading the prescriptions in the other locations, when they come in?

Mr. SUTHERN. We do have pharmacists in Ohio and New Jersey pharmacies reading prescriptions, we do have technicians assisting them. I would say it varies from week to week. I would imagine it would be around 50 percent, is the split between a registered pharmacists and a technician. They sit side by side and they are under the personal supervision of a registered pharmacist.

Senator SASSER. So in some of your plants you have got pharmacists that read the prescriptions, in other plants you have got a mix of pharmacists and technicians who read the prescriptions.

Mr. WYGOD. That is correct.

Mr. SUTHERN. That is correct, Senator.

Senator SASSER. In any of your plants do you have solely technicians who read the prescriptions?

Mr. SUTHERN. Not 100 percent, Senator. As I stated, in Ohio and New Jersey, it would be a mixture between the two.

Senator SASSER. What would the mixture be, in your estimate?

Mr. SUTHERN. I estimated 50 percent just a minute ago. I do not really have any hard information on that with me.

Senator SASSER. All right. After the prescription is read, then what happens?

Mr. SUTHERN. It goes to a data entry station where we will have a CRT operator enter it into a patient profile system, which would entail——

Senator SASSER. I did not quite understand that. Enter it into a patient what?

Mr. SUTHERN. We have a patient profile system.

Senator SASSER. All right.

Mr. SUTHERN. It is the history. The CRT operator will enter that into our computer system, the name, the directions, the drug codes. In our pharmacies we have about 75 percent of that prescription, the computer will figure out the number of refills and the quantity to be dispensed.

Senator SASSER. Then just describe the rest of the operation.

Mr. SUTHERN. In Ohio and New Jersey it will go to filling stations that will be employed by technicians and they will fill——

Senator SASSER. The technician reads the prescription—or reads the order form and they hit the button that will dispense the prescription?

Mr. SUTHERN. The technician is trained to read the prescription, the label, and then to access either the baker machines or the carrousels that you have heard about before.

Senator SASSER. Now, does the technician ever see the actual tablet or pill that is dispensed into the bottle?

Mr. SUTHERN. All the time.

Senator SASSER. Well, do they always see it?

Mr. SUTHERN. Yes, sir. Except for an ointment or a cream where it is a unit of measure where they would not open the box because there is no reason to count it. They would take the ointment and put it in the order pan and bring it to the next station.

Senator SASSER. What happens after that?

Mr. SUTHERN. In Ohio and New Jersey, it will go to the registered pharmacists who will check the entire order again, to ensure that the order is correct. He will check the medication that is going out of the facility to the original prescriptions or to the refill ticket that came in.

Senator SASSER. Now, what is the error rate that is picked up there at the final checkpoint? What percentage of prescriptions are erroneous?

Mr. WYGOD. Excuse me, I just think it is important to understand that we do not consider it an error unless it leaves our pharmacy and is incorrect. The pharmacists look at errors that—in other words, if the system prevents the drug from leaving because of the checks or double checks or triple checks and goes back, the pharmacist looks upon that as an error in our facility. We do not look at it as an error unless the drug actually leaves the facility as incorrect. I just wanted to make that point. Sorry, Paul.

Mr. SUTHERN. OK. I would say, Senator, that approximately 3 to 5 percent of our orders are returned for correction. The majority of the time it is because we have made a typographical error entering into our patient profile system.

Senator SASSER. In other words, 3 to 5 percent are returned after the pharmacist has checked the prescription? That is what you are telling us?

Mr. SUTHERN. That is correct.

Senator SASSER. Now, when a prescription has been incorrectly filled and the mistake is caught by the pharmacist before it gets out the door, what happens then to the medication that was incorrectly filled?

Mr. SUTHERN. The medication has to be returned to stock. It goes to a registered pharmacist supervisor and either he or another registered pharmacist or a technician under his employ will return it to stock.

Senator SASSER. So it is returned to stock. Now, what prevents you from mixing various batch numbers when it is returned to stock? In other words, as I understand it, the Food and Drug Administration and the pharmaceutical manufacturers require that the various batch numbers be numbered and records kept of those. So what prevents your medications, when they are returned to stock, from being mixed together?

Mr. WYGOD. I would like to answer that. To begin with, if it is returned to a baker machine—just so everybody understands—a baker machine, or the baker machines that we use in our facilities—are specifically calibrated in such a way that only one drug can go through the mechanism. Any drug of the slightest different size cannot go through that process. That is an extremely effective way of preventing that from happening if it is going into any of the baker equipment or baker machines.

If it is going back to the carrousels, it has to be put back into the actual original package it came out of. A pharmacist is returning this. We do not believe errors are made that way.

Mr. SUTHERN. Senator, we do keep records of the individual stations such as the baker machines about lot number, baker sizes. It happens so frequently, of returning medication, that I am just not that much aware of the procedure.

Senator SASSER. Well, you say that you are returning 3 to 5 percent to stock, are you not?

Mr. SUTHERN. No, sir. I said that 3 to 5 percent of the orders are returned for some sort of correction. The majority—the great majority—of these medications, it is not a filling error, it is a typographical error; we keyed in somebody's address wrong, we might have keyed their name wrong, we might have keyed in the doctor's name wrong. That is what most of them go back for.

It is an extremely small percent—from the studies we have done, it is ten-thousandths or a hundred-thousandths percent of what goes back. It is a very, very small amount that is actually misfilled.

Senator SASSER. Well, what happens to the medication, the 3 to 5 percent that you say there is something wrong with and the pharmacist catches? What happens to that medication?

Mr. SUTHERN. Most of the times that it is a typographical error, it will be reviewed again by a registered pharmacist supervisor to ascertain again what needs to be done, and as most cases it is a typographical error, it will go back to our CRT operators, be re-entered into our system, the old labels will be destroyed and it will be sent back to a checking pharmacists to send out again.

Senator SASSER. Well, then are you telling this Subcommittee that, if information has been furnished is correct that these medications are stockpiled by the pharmacists, those that had been found to be erroneous, and then collected on a daily basis by an assigned pharmacists or technician and then the drugs are placed in cardboard boxes with a locator label wrapped around the container and that they are then dispersed into the baker cells or bulk containers using the locator label as a guide, and that the expiration date and lot number are not considered, you are telling us that this information is in error?

Mr. MAROTTA. Can you repeat that, Senator? I was a little confused whether that was a question or statement or recitation of previous testimony.

Senator SASSER. Well, I am asking you if this information is correct or not. I am giving you an opportunity to say it is not, if you wish to.

Mr. MAROTTA. Can you read it again for us or give us a copy of what you have there to look at?

Senator SASSER. I would be glad to read it again. Let me just read it to you again. Just listen carefully.

The Subcommittee has been furnished information that the medications in the prescriptions that are believed to be erroneous are stockpiled by the pharmacist that catches it. They are collected on a daily basis by an assigned pharmacist or technician. The drugs are then placed in cardboard boxes with a locator label wrapped around the container saying where it is to go. They are then dispersed into the baker cell or bulk containers using the locator label as a guide as to where they are to go. And the expiration date and lot number of this medication is not considered. They are simply returned to stock.

Now, does this happen or does it not happen?

Mr. SUTHERN. The lot numbers and the expiration dates are at the baker cells; they are at the verticals. They are to be taken into consideration. I have not heard that before. The procedure is to take them into account. We buy in sufficient quantity that with these logs that we keep at our baker machines, that a particular lot of batch, our expiration date will be on the floor for quite awhile, and since we return things almost of an immediate nature, and they have an order trail to go back to see if things have been changed, I am assuming that they are checking that, Senator. I cannot tell you, because that is the first time I have heard that.

Mr. WYGOD. Paul, would you be able to follow through and get that information for the Senator?

Mr. SUTHERN. Yes, I would be able to follow through.

[The information furnished follows:]

A drug which is to be returned to stock within the system is labeled with the prescription control label that has the locater code printed on it via the computer printer. At the beginning of each day, the drugs are taken from a central cabinet and returned to the Baker cells. Drugs that need to be returned to the vertical cabinets are placed back into the original containers. Due to the stringent protocol employed by Medco and the fact that Medco's prescription volume mandates large inventory purchases, the lot number and expiration date of all drugs returned to stock can be strictly audited and verified.

Senator SASSER. But you cannot tell us today whether this allegation is correct or incorrect; you just simply do not know?

Mr. SUTHERN. The procedure is to take into account the lot numbers and the expiration dates that are at the baker machines and the order trail that has been established.

Senator SASSER. Let's take a hypothetical case. A pharmacist technician fills a prescription incorrectly in one of your plants where you have got a technician who fills it. How is this prescription prevented from being mailed out?

Mr. SUTHERN. In the facilities that we use technicians, the checking pharmacist is to open the vial, look inside and pour out and look at the drug or medication that is inside the vial and he is to check that to the original prescription.

Senator SASSER. Do you mean running 53 prescriptions an hour by the pharmacist, he will open it up, pour it out, look at it, put it back in the bottle, read the prescription and let it go?

Mr. SUTHERN. He will not empty out the entire vial. He will take a look to see if it is the correct medication internally.

Senator SASSER. Let's say that the staff pharmacist who is sitting there and trying to hit the—we do not have a quota—but trying to make the number of prescription reads or checks that he or she is supposed to make, let's say that after opening the bottle, looking in there, putting the top back on, reading the data that comes with the bottle, he or she then misses the fact that there is a drug in here that should not be in there. Are there any steps after that to correct the problem before the mail-out goes?

Mr. SUTHERN. They are the pharmacist of record. They are the checking pharmacist.

Senator SASSER. Now, with regard to error rates, I assume that you furnish telephone numbers that your customers can call in to your firm on and make inquiries or lodge complaints?

Mr. SUTHERN. That is correct, sir.

Senator SASSER. Now, how many telephone lines do you have system-wide in which they can call in and get information or lodge complaints; do you know?

Mr. SUTHERN. I do not know off the top of my head how many phone lines we have.

Senator SASSER. Would you be good enough to make an inquiry and furnish the Subcommittee with that information?

Mr. SUTHERN. I sure will.

[The information referred to follows:]

There are 175 incoming lines. There are 56 outgoing lines. There are 61 additional lines used for administrative purposes.

Senator SASSER. Now, those individuals who answer the telephones in which the complaints come in or requests for information come in, are they pharmacists or are they technicians?

Mr. SUTHERN. There are customer service representatives that take the initial phone call. We find the majority of our phone calls are about the status of an order, what the co-payment is, the plan rule, what kind of drugs are covered, which they have computerized into our main files to look up. If there is any question about a drug or medication, it gets turned over to the registered pharmacist in that department.

Senator SASSER. What percentage of the calls that you get are complaints about getting the wrong medication?

Mr. WYGOD. Senator, let me just partially respond to that.

Senator SASSER. Well, Mr. Wygod, why do not you let him respond? In other words, let's see what he says. He is your operations manager.

Mr. WYGOD. Sure.

Senator SASSER. Then we will be glad to hear from you.

Mr. WYGOD. Fine.

Mr. SUTHERN. The percentage is approximately .012 percent of alleged incidents of wrong medication going out.

Senator SASSER. Would you repeat that, please?

Mr. SUTHERN. Point 012 percent.

Senator SASSER. Is that system-wide?

Mr. SUTHERN. That is for the entire company, sir.

Senator SASSER. For the entire company.

Now, did you wish to make a statement, Mr. Wygod?

Mr. WYGOD. Only that you should take into consideration that a large percentage of the people that are receiving the drugs from us are elderly. Some of them are receiving the generics for the first time, and it is very normal for us to receive a tremendous number of telephone calls from individuals when they first receive their first prescription if we have done a generic substitution.

Mr. SUTHERN. Senator, there are a number of phone calls, which I do not know of, where somebody will call in and say, the doctor wrote for a 90-day supply, why did I get for a 30? That is being answered and there is not a problem, and that number I do not have. But there are a considerable number of phone calls like that.

Mr. WYGOD. The only other thing that I thought might be helpful is, how many people do you have on the phones answering? If you do not know how many lines?

Mr. SUTHERN. Well, it depends on the size of the pharmacy. In Tampa we have I think approximately about 25 customer service reps and pharmacists in that department, from 8 o'clock in the morning to 8 o'clock at night.

Senator SASSER. Does the customer speak directly with the pharmacist who either filled or checked his or her prescription at any time? Or do they just speak to whoever happens to be available there at that time?

Mr. SUTHERN. Most of the time they will talk to the customer service pharmacists that are assigned to that area.

Senator SASSER. Most of the time. But what percentage of the time would they talk just to the individual who answers the telephone, the customer service representative? What percentage of the time would they talk to them as opposed to talking to the pharmacist? Do you know?

Mr. SUTHERN. I think on the initial phone call it is usually approximately 100 percent. They are taken by our customer service reps and turned over to a registered pharmacist if there is any question about the medication. Again, most of our phone calls are not about the medication.

Senator Sasser. Let's take an example where a Connecticut doctor notes on his prescription that a generic drug should not be substituted for a brand-name drug, because for some reason he thinks the brand-name has greater purity, or for whatever reason. And the Connecticut physician makes this notation according to the State law of Connecticut.

Will his instructions be followed even though the prescription may be filled by your plant in Ohio or your plant in Florida, for example?

Mr. Suthern. If the doctor notes on the prescription, "do not substitute," we will not substitute.

Senator Sasser. I could not hear you there.

Mr. Suthern. If the doctor writes on the prescription that substitution is not permissible, we will not substitute.

Senator Sasser. What if he says something other than "substitution not permissible?" In other words, as I understand it, there are sort of words of art with different States as to whether or not you can substitute a generic for a brand-name; is not that correct?

Mr. Suthern. I think 22 States, Senator, have a 2-line script where the intent of the doctor is clearly indicated.

Senator Sasser. How about the other States?

Mr. Suthern. The other States, if——

Mr. Marotta. If I might, Senator, that is really a legal question that is translated into operations. In the other States, the company's policy is we will honor the practitioner's intention. If the practitioner has marked the prescription "brand-name" or "dispense as written" or "do not substitute," we will honor his intention. It is a popular fiction, spread for whatever reason I do not quite understand throughout this country, that mail service disregards practitioner's intentions when filling prescriptions.

Speaking for Medco, I can tell you we do not, and if it is occurring, we would certainly like to know.

Mr. Wygod. Also Senator, just so you understand, we make substantially more money in dispensing the brand than we do the generic.

Senator Sasser. How is that, Mr. Wygod?

Mr. Wygod. The price of the brands are substantially higher. Therefore, when we are operating at some percentage off of AWP in the pricing to a funded plan, the entire amount or the profit of the prescription would be greater because the dollar amount is four to five times greater for the brand than the generic.

Senator Sasser. Well, gentlemen, the hour is late. I think we have held you here long enough.

We have heard testimony that suggests on occasion there are problems that are associated with the safety and soundness of dispensing prescriptions drugs by mail service pharmacy. Now, this may be a rare occurrence that we have heard here today. It may not be.

I certainly hope that what we have heard from some of the witnesses are only isolated cases, but if they are not, then I believe the mail service pharmacy industry would be wise to examine their various internal procedures to ensure that the highest levels of soundness and safety are subscribed to.

I will just have to tell you, frankly, that some of the testimony I have heard here today gives me pause. The question of Mrs. Owens getting a blood thinner instead of the drug that was to treat her for hypertension. That concerns me.

Mr. Wygod stating that many of their customers are elderly people. They are not in a position, really, to be able to check their prescription the way they should. They generally will take just what is sent. So clearly, they are entitled to a very, very high standard of care.

The mail order drug industry is a growth industry. It is undergoing what I would characterize as almost an explosive growth, as manifested by the growth of your firm, Mr. Wygod. In a period of great growth like that, many times it is very, very difficult to maintain the quality standards that the mail order firms themselves might wish to maintain.

So we are going to continue to examine this question and it may be that there will be calls for more stringent Federal regulation of the mail order drug industry and we may find that before it is over the mail order drug industry itself might even welcome such regulation or such supervision.

But I think we will all agree that we do have a solemn obligation to see that the consumer gets his prescription drugs, gets what he or she ordered in the proper dosage and the proper drug.

Gentlemen, I appreciate your testimony——

Mr. **Marotta**. Excuse me, Senator. Medco would move the right to supplement the record.

Senator **Sasser**. You certainly may. We would be delighted. In fact, we have asked you to supplement a number of your answers, and this record is going to be held open for at least 10 days after the conclusion of the hearings tomorrow for any interested witnesses or citizens who might wish to supplement their testimony or simply file a statement.

Mr. **Marotta**. Thank you, Senator.

Mr. **McMahon**. May we have a chance for rebuttal, Senator?

Senator **Sasser**. Well, I will tell you what we are going to let you do. We need to adjourn now, and we will let you file a written rebuttal, and you may be assured that the Subcommittee will read it with interest.

Gentlemen, thank you very much, and the Subcommittee is in recess.

[Whereupon, at 5:35 p.m., the Subcommittee adjourned subject to the call of the Chair.]

SAFETY AND SOUNDNESS STANDARDS IN THE MAIL ORDER PRESCRIPTION INDUSTRY

THURSDAY, AUGUST 6, 1987

U.S. SENATE,
SUBCOMMITTEE ON GOVERNMENT EFFICIENCY,
FEDERALISM, AND THE DISTRICT OF COLUMBIA,
COMMITTEE ON GOVERNMENTAL AFFAIRS,
Washington, DC.

The Subcommittee met, pursuant to notice, at 10:35 a.m., in room SD-342, Dirksen Senate Office Building, Hon. Jim Sasser (Chairman of the Subcommittee) presiding.

Present: Senators Sasser and Heinz.

OPENING STATEMENT OF SENATOR HEINZ

Senator HEINZ [presiding]. The Subcommittee will come to order.

Senator Sasser, who chairs this Subcommittee, is at a meeting at the White House and will still be somewhat delayed. He anticipates being here in the next 10 or 15 minutes.

As a courtesy to the witnesses, he has asked me to proceed with the hearing and we will do that in order to expedite the testimony and to facilitate the schedules of all involved.

I am sure Senator Sasser will have an opening statement when he arrives. I myself have some comments I would like to make about the subject of these hearings.

As I think most people know, we are continuing the Subcommittee's hearings this morning on the safety of mail order pharmaceuticals. Today we are going to hear from the Office of Personnel Management, the Veterans' Administration, and a panel representing the National Association of Mail Service Pharmacies.

I note that the latter panel contains several Pennsylvanians—Mr. Don Bell, Mr. Robert Waspe, and Mr. Dennis Santo. I want to welcome my constituents before the subcommittee this morning.

I stated yesterday that there are really two issues before the subcommittee. One has to do with the operation and safety of the Federal employees Health Benefits Program's use of mail order pharmaceuticals. There are approximately 1 million Federal employees enrolled in such plans which provide mail order drugs, often at a lower price than retail outlets.

The other issue before us, which has been touched on, perhaps a bit vaguely, is the overall safety of interstate mail order operations.

Mr. Chairman, I will just take another minute and then I will be glad to turn the gavel over to its rightful owner.

Senator SASSER. You go right ahead, Senator.

Senator HEINZ. All right.

Of these, the Veterans' Administration is the largest dispenser of mail order drugs, having been in this business since the end of the Second World War. Other dispensers—the American Association of Retired Persons, Medco, Thrift Drug and others—they, too, are supplying pharmaceuticals by mail.

The Subcommittee is seeking any reliable information as to whether or not mail order drugs are less safe than drugs from retail pharmacies. Ironically, last night I am advised everyone on my staff who subscribes to the Blue Cross/Blue Shield program received a little notice in the mail encouraging them to use Medco's mail order pharmaceuticals.

I have a copy of that brochure and, Mr. Chairman, in view of your great interest in this subject, I would ask that these be a part of our record.[1]

Senator SASSER. They will be included in the record, Senator Heinz. Thank you.

Senator HEINZ. I would note that the Blue Cross/Blue Shield brochure—which is this one printed in blue—which was actually sent by Medco, differs significantly from that used by the Express Pharmacy Service—which is this one—a subsidiary of J.C. Penney, of which by the way, Thrift Drug is a subsidiary.

At the bottom of Express Drug's pamphlet, there is a paragraph describing their guarantee:

> All prescriptions will meet the highest standards of quality, safety and effectiveness. Each and every prescription is filled and checked by highly qualified registered pharmacists.

And it goes on.

There is no such guarantee on the Medco pamphlet, which Blue Cross/Blue Shield has distributed to my staff, and this morning I would like to learn, among other things, why not.

I fully understand the benefits of mail order pharmaceuticals to the elderly, the disabled, and the homebound. We must, however, be assured that as the Express Pharmacy pamphlet states, the highest standards of quality are met.

Mr. Chairman, I want to thank you for this brief period of fame as acting Subcommittee Chairman. It was as pleasurable as it was brief and I thank you for having given me this brief opportunity to shine, however minimally, in the constellation of stars and witnesses out there.

I, obviously, look forward to reviewing today's testimony. Without further ado, I will get out of this chair.

Senator SASSER. Well, thank you very much, Senator Heinz. Just let me say that you appear to have had quite a bit of experience in chairing this Subcommittee. You did it very well.

I apologize to you, Senator Heinz, and also to others for my absence. Some of us were asked over to the White House this morning to meet with the President on the whole question of what is to be done with regard to policy in Central America, and that is the tangled web that we have been trying to unravel this morning.

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[1] See p. 274.

Senator HEINZ. Mr. Chairman, before you go any further let me say it was a pleasure. I would be willing to make this either on a temporary or permanent basis, whatever suits you.

Senator SASSER. Thank you very much. I am inclined to think we will keep it on a temporary basis. [Laughter.]

OPENING STATEMENT OF SENATOR SASSER

Senator SASSER. Today the Subcommittee on Government Efficiency, Federalism, and the District of Columbia begins the second day of hearings on the whole subject of safety and soundness standards in the dispensing of prescription drugs through the mails.

Yesterday the Subcommittee heard some very chilling testimony with regard to the dispensation of drugs from mail service pharmacies. One consumer from Virginia Beach received an incorrect mail order prescription drug which was of a life threatening nature.

Several registered pharmacists testified about the use of the so-called quota systems that were to be followed in the filling and dispensing of prescription drugs. They noted their grave professional concern with other practices relating to the dispensation of prescription drugs by at least one mail order firm.

The leading for-profit mail service pharmacy noted that perhaps as much as 5 percent of all prescriptions handled at some of their facilities were filled in error, whether the prescription had an incorrect address, a prescription drug with an improper dosage, or a prescription that contained an improper drug. To be fair, the same firm denied that that percent of improper prescriptions left the door and reached the consumer.

So such testimony does give us pause for, as I mentioned yesterday, mail service pharmacies are a growth industry. They are striving to serve an ever greater share of the prescription drug market. Indeed, the growth in some quarters of this industry have been nothing short of explosive.

Today we will hear testimony from the Office of Personnel Management, from the Veterans' Administration, and several major mail service pharmacies about the safety and soundness standards in mail service pharmacy.

I look forward to this testimony and I believe that the American public does also. The American prescription drug consumer has a right to know about the quality control standards that are put in place to ensure that he or she will have their prescription filled to the highest possible standards of safety and soundness.

If the highest quality controls are not followed, suitable Federal regulation may well be necessary to ensure that mail order prescriptions are dispensed with the care and concern that is required to prevent consumers from receiving incorrect prescriptions.

Today our first witness will be Ms. Jean M. Barber, Associate Director for Retirement and Insurance for the Office of Personnel Management.

We have asked OPM here today so as to inquire of their basic responsibilities in reviewing and monitoring this feature, the mail service prescription option, of the Federal Employees Health Benefit Plans that they administer.

If you would be good enough to come forward, Ms. Barber, we will begin. We welcome you here this morning and look forward to hearing your testimony and you may proceed.

TESTIMONY OF JEAN M. BARBER, ASSOCIATE DIRECTOR FOR RETIREMENT AND INSURANCE, OFFICE OF PERSONNEL MANAGEMENT

Ms. **Barber**. Thank you, Mr. Chairman. Director Horner regrets that she cannot be here this morning.

I appreciate the opportunity to present OPM's views on mail order pharmacy programs offered by carriers in the Federal Employees Health Benefits Program. OPM administers the FEHB program under the provisions of chapter 89 of title 5, United States Code.

OPM's responsibilities include the negotiation of contracts with insurance carriers for the reimbursement of services provided to enrolled Federal and Postal employees and their families. OPM's role is similar to that of private sector employers who sponsor an employee health insurance program utilizing private carriers to provide or reimburse medical services and supplies.

OPM has no authority and no capacity to set safety standards or any other type of standards for any part of the health care industry. In addition to mail order drugs, our insurance contracts cover hospital services, physician and surgeon services, clinics, laboratories, x-rays, birthing centers, hospices and non-mail order prescription drugs.

In all categories we, like other employers, rely on the existing Federal and State regulatory bodies and certifying agencies to determine by whom and under what conditions these services may legally be rendered. Similarly, we have no authority and no capacity to review or monitor the provision of any medical service but rely in this area as well on the existing review and oversight authorities.

Our role as the contracting agent for Federal enrollees is primarily to define through negotiations with the carriers what benefits will be offered and what premiums will be charged and to assure that the agreed upon benefits are in fact provided at the agreed upon price. What subordinate arrangements are made for the actual provision of services is up to the carrier.

The Blue Cross/Blue Shield Association has thousands of agreements with medical providers of all types across the United States. Our other carriers also have agreements with many provider groups, including mail order drug companies. These medical provider contracts between private parties are not now and never have been subject to the procurement regulations that govern the FEHB.

Federal law and regulation govern only the contractual relationship between OPM and the carrier and subcontracts the carrier may enter into for administrative purposes. Indeed, a program such as FEHB would be utterly impossible if the tens of thousands of subcontracts governing the actual provision of medical services to the 9 million people covered under our nearly 400 insurance plans were subject to review and regulation by OPM.

OPM agreed to add a mail order drug program to the benefits offered under the 1987 Blue Cross/Blue Shield contract based on our favorable experience with such programs in our other health plans. We have had mail order drug programs in the FEHB since 1985 and our experience has been very positive. To date, approximately 2.5 million prescriptions have been filled for Federal enrollees by mail order. For the 1987 contract year, 20 fee-for-service plans are offering mail order drug programs to a combined enrollment of over 2 million people, and with dependents that is 5 million people.

We believe these programs provide significant savings to our enrollees, particularly to the elderly, who are likely to use the maintenance-type drugs most readily filled on a mail order basis. We have seen no substantial evidence to suggest that mail order drug programs pose significant safety hazards to our enrollees, and the utilization rate for these programs suggests that enrollees concur in this opinion.

If the Subcommittee has any evidence to the contrary, we request that it be shared with us and with the carriers who participate in our program.

I will be happy to answer your questions.

Senator SASSER. Thank you, Ms. Barber.

If I understand you correctly, the Office of Personnel Management sees its role in negotiating contracts with private health insurers as one of cost cutting only. But it appears to me that the Federal Government ought to have an obligation to its several million employees to oversee not just the cost of the health benefits that they are offered, but also the quality of these programs.

In fact, as I understand it, the law—the U.S. Code, title 5—requires OPM to make: ". . . a continuing study of the operation and administration of the Federal health insurance program, including surveys and reports on health benefit plans available to employees, and on the experience of the plans," the experience the employees have with the plans.

Now, OPM does engage in rather extensive negotiations with private carriers each year with regard to health programs; is not that correct, Ms. Barber?

Ms. BARBER. Yes, we do.

Senator SASSER. Well, can you tell me what proportion of these negotiations concerns the price of health benefits and what proportion deals with the substantive nature of the benefits offered?

Ms. BARBER. That depends on the year you are talking about, sir. This program has been in business for 27 years and many of our plans have been in the program that long and they go forward from year to year, often with fairly minor changes in the benefits provided.

Where there are new benefits offered, there is discussion of that benefit. Where there is any question about continuing a benefit, there is discussion of that benefit.

Lately we have been in a period when the cost of medical care is so great and the premium increase is so great that we have been unable to add new benefits at a price anyone could afford. Therefore, benefit enhancements have been very limited in recent years and the discussion of benefit enhancement has been limited.

I would like to object, however, to your characterization of OPM's role as interested in price only. The fact that we do not have regulatory authority over the safety of medical services should not be interpreted to mean that we are not concerned with such factors. That is simply not the statutory role that was assigned to OPM.

Senator SASSER. Well, do you inquire as to the quality of the health care that is being dispensed to Federal employees?

Ms. BARBER. Do we inquire into it? If we have any reason to. Our people are getting medical services of all types all over the United States, in virtually every State and virtually every sizable community.

There is no way that OPM—except but when something is brought to our attention by an enrollee—can have any question or hope to have any information about hospital X in city Y in State Z, or physician X, et cetera. The provider universe out there is enormous and there is no way that we can, and indeed, we have no authority and no capacity to monitor the quality of medical services. No sir, we could not do that.

Senator SASSER. Well, certainly you make a cursory survey to determine whether or not the health care provider provides quality services. If a fly-by-night drug company shows up and tells you, we are going to sell you drugs at one-tenth of 1 percent of what others are going to sell you the drugs for, does not that raise the danger flag with you?

Ms. BARBER. Senator, OPM has no conversations with drug companies. We only deal with carriers—with insurance companies and plan sponsors. They, in turn, deal with drug companies and other medical providers—hospitals, physicians, nursing homes, clinics, laboratories, whatever.

Senator SASSER. Well, have you had any experience with mail order drug programs?

Ms. BARBER. We have had mail order drug programs—as I just testified—in the program since 1985. Our experience with them has been overwhelmingly positive.

Senator SASSER. Overwhelmingly what?

Ms. BARBER. Overwhelmingly positive. By that I mean, indications are to us that our enrollees are extremely satisfied with this program. The level of complaints is miniscule. The one incident that was testified about here I understand yesterday is the only case of its kind in OPM's files over this 3-year period. It was an unfortunate incident. We were satisfied that it was appropriately dealt with by the carrier and the provider.

Senator SASSER. How do you determine whether or not your employees are having a favorable experience? Just based on complaints that come into the office? How do you determine that?

Ms. BARBER. When they are not having a favorable experience, we know that because they have no shyness about telling us. They do have a statutory right to appeal any dispute that they are having with one of the carriers in any part of the health benefits program to OPM, and they do that quite regularly.

Senator SASSER. Well, you are telling this committee that you have only had one complaint, and that was the one that appeared here yesterday?

Ms. **Barber**. We have only had one complaint that dealt with the mail order drug program with a dangerous substitution, or in fact, with any substitution, any mis-filling of a prescription; yes, that is what I am telling you.

Senator **Sasser**. How about other complaints? How about complaints about late deliveries and that sort of thing? Do you get any complaints of that sort?

Ms. **Barber**. There have been a handful of letters written to us complaining mainly about timeliness, primarily when these programs first started up.

Senator **Sasser**. So you are now amplifying on your previous answer when you said you had had only one complaint, and that was the complaint of Mrs. Owens, who appeared here yesterday.

Ms. **Barber**. One complaint that dealt with safety.

Senator **Sasser**. You are now telling the Subcommittee that, indeed, there were other complaints.

Ms. **Barber**. One complaint that dealt with safety, Senator.

Senator **Sasser**. Has OPM, to your knowledge, ever requested or received any report from any insurance carrier regarding the continuing operation of the mail order drug programs? In other words, do you just turn it over to the insurance carriers and that is the end of it?

Ms. **Barber**. The provider contracts are the business of the insurance carrier. That is true whether they are for drug services or for any other medical services. They have no obligation to give us reports on that. We can ask, and they are extremely cooperative and they will tell us. If we have any reason to suspect that a problem exists, we will ask, and we do ask. But there is no ongoing obligation on their part to submit reports about provider services to OPM; no, sir, there is not.

Senator **Sasser**. So if the employees are writing to the health benefit plan office rather than OPM, you know nothing about what may be happening with regard to the quality of service that the employee is getting?

Ms. **Barber**. If they get satisfaction at that level, I would not hear about it. If they do not, they write to OPM.

Senator **Sasser**. All right. Senator Heinz?

Senator **Heinz**. Mr. Chairman, I have really one question, which is, What comment do you have on the fact that the Blue Cross/Blue Shield brochure that I referred to earlier and which, in effect, is a subcontractor to the Federal Government, has no warrantee of quality comparable to this private warrantee that I described earlier from Express Pharmacy Services?

Ms. **Barber**. Senator, I have never seen those documents and I have no comment on it. I would not conclude from the lack of a warranty on a brochure that there is any less safety behind the operation. It seems to me good advertising to put it on the brochure, but——

Senator **Heinz**. Do we know whether registered pharmacists check and recheck the filling of prescriptions through Medco?

Ms. **Barber**. We do not know. The pharmacy operation operates under the laws of the State where it is located and is subject to review by the Board of Pharmacy in that State. I would assume that they are following the laws and the regulations of the State where they are operated. I have no information to the contrary.

Senator HEINZ. Well, all of that is very interesting, but should not we care? I mean, it is one thing for them to follow State law. It is another for them to meet standards that we, the people paying for this, feel are reasonable. It is not, to me, obvious that a State necessarily has standards that are up to the specifics that we might want.

I can imagine considerable variability among the States. Indeed, I can imagine some States that never thought of it. And so I do not find your answer to be sufficiently interesting and responsive to what I am asking you.

What I am asking you is, should we—irrespective of whether the States have some law—we are the people paying the money. They are not. Do we have an interest in making sure that what the Federal Government is doing is quality competitive—in terms of quality competitive with what the private sector is, at least in some instances, doing? And if so, what are our responsibilities as Federal managers to doing something about that?

Ms. BARBER. Sir, if we thought there was a problem, a significant problem here, I believe we would be in favor of doing something about it. I do not think OPM is equipped as an agency to set standards or enforce standards for the pharmacy industry.

Senator HEINZ. Who is talking about that?

Ms. BARBER. There may be some other part of the Federal Government that is.

Senator HEINZ. Ms. Barber, excuse me. I do not mean to cut you off, but that is irrelevant to what I am asking. No one is asking you to set the standards for the pharmacy industry. I am not asking you to do that.

Now, you can answer my question or you can chase after shibboleths that are irrelevant. It is your choice and it is your time.

Ms. BARBER. I thought I understood your question. Perhaps I did not.

Senator HEINZ. No. We are a purchaser, OK?

Ms. BARBER. Yes, we are purchaser.

Senator HEINZ. Now, no one can tell me that the purchaser does not have some rights; indeed, some responsibilities. So all I am asking you is, as the people who pay the bills—you pay the bills, do you not?

Ms. BARBER. The taxpayer pays the bills.

Senator HEINZ. Yes. But you are their agent, are you not?

Ms. BARBER. Yes.

Senator HEINZ. You physically oversee or subcontract the paying of those bills; right?

Ms. BARBER. Yes.

Senator HEINZ. So you are in a fiduciary capacity serving for the taxpayer?

Ms. BARBER. Correct.

Senator HEINZ. Now, in that fiduciary capacity, what are your responsibilities?

Ms. BARBER. Senator, we believe that we are getting good value for our money. We have no indication, seriously, that we are not.

Senator **Heinz**. Well, I am not asking you to make a judgment as to whether or not you are getting good value or good quality. I am asking you a much simpler question. Do you have a responsibility in that regard?

Ms. **Barber**. Do I have a responsibility to—and let me make sure I understand you—are you asking do I have a responsibility to ensure the quality of the medical services, all medical services that are rendered to Federal employees under the FEHB?

Senator **Heinz**. Yes, including this one, specifically.

Ms. **Barber**. I think that would be an impossibility.

Senator **Heinz**. A what?

Ms. **Barber**. I do not see how we could possibly do that.

Senator **Heinz**. You have no responsibility for the quality of services that you——

Ms. **Barber**. We have a——

Senator **Heinz**. Just a minute. I just want to be clear in what you are saying. You are saying you have no responsibility for the quality of services that you in a fiduciary capacity to the taxpayer are charged with overseeing?

Ms. **Barber**. I am saying I have no front-end capacity to assure that people will receive——

Senator **Heinz**. I am not asking whether you have capacity. I am asking whether you have responsibility.

Ms. **Barber**. Yes. I think I have responsibility, and where we are aware that substandard services are being rendered, we will take action on that.

Senator **Heinz**. I am sure you will.

Ms. **Barber**. Yes.

Senator **Heinz**. But I am just trying to get a very simple answer to what I thought was a simple question. Why did you dodge it?

Ms. **Barber**. I did not dodge it, Senator. I think we had a confusion, or I had a confusion as to what you were asking.

Senator **Heinz**. Well, I am sorry if I have contributed to that confusion.

To what extent do you think it would be important to know that the mail order drugs that you are paying for are in fact treated in a way that is commensurate with and meets the standards of quality of other competitive private sector services? To what extent is that a question you should be interested in having an answer to?

Ms. **Barber**. I am interested in having an answer to that. I would also be interested in knowing the quality of all the services that are provided under our program.

Senator **Heinz**. I am sure you would, but this hearing is only on one—this one.

Now, do you believe it is your role to ask questions like the one I just asked you, such as, are we getting the kind of quality out of this program or that program that is commensurate with what is available from the private sector?

Ms. **Barber**. Senator, we have discussed these programs with all of our carriers. We have had reactions from our enrollees. We have discussed them with the Federal employee unions who sponsor many of our health plans. We are, I think, collectively convinced that these programs are operating well. If we were not so convinced, we would——

Senator **Heinz**. I am just asking if you have asked this particular question——

Ms. **Barber**. Have we asked this? In conversations with our carriers, yes, we have asked this question.

Senator **Heinz** [continuing]. Or whether you feel that it is the right question to ask?

Ms. **Barber**. I feel it is a question to ask and we have certainly discussed the operation of these programs with our carriers.

Senator **Heinz**. Now, to answer that question, somebody needs to do a very simple survey of the literature. Has anybody done a survey of the literature?

Ms. **Barber**. Of the literature?

Senator **Heinz**. Yes.

Ms. **Barber**. Yes. We very much keep abreast of developments in health care in this area.

Senator **Heinz**. Well, I am talking about prescription drugs and the quality aspects of them.

Ms. **Barber**. Well, I do not know that I can tell you we are aware of everything that has been written on the subject, but we generally keep abreast of these issues; yes, we do.

We also talk to private corporations who have similar programs and we are interested in their experience.

Senator **Heinz**. All right. Well, I do not know to what extent that search of the literature is followed through. I would urge you to look and see what kinds of quality procedures and guarantees are used in the private sector. You are going to find a range of differences in the private sector. Some will have very high commitments and procedures aimed at assuring quality; others less so.

Let me urge you further to not be second best. It seems to me a relatively simply thing to do, and hopefully on some other occasion when there is a further correspondence between this Committee and your office, we will have the kind of answers to that subject that my line of inquiry implies.

Thank you very much.

Ms. **Barber**. Thank you.

Senator **Sasser**. Thank you, Senator Heinz.

Just one final question, Ms. Barber. It is my understanding that two mail order drug companies made a detailed presentation to the Office of Personnel Management in, I believe, 1982 or 1983 when the question of mail order programs was first being considered for inclusion in the Federal health benefit programs; are you aware of that?

Ms. **Barber**. No, sir.

Senator **Sasser**. Well, would you be kind enough to review your files at OPM and furnish this Subcommittee with any of the materials that you were presented with at that time by the mail order drug companies at this 1982 meeting, or any other presentations that the mail order drug firms may have given to OPM subsequent to the 1982 meeting? [1]

Ms. **Barber**. Yes, sir.

Senator **Sasser**. Thank you, Ms. Barber.

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[1] See p. 623.

Our next witness is Dr. David Law, the Deputy Assistance Chief Medical Director for clinical services at the Veterans Administration.

Dr. Law, if you would, please come forward.

Welcome, Doctor. We are delighted to have you here this morning, and if you would be kind enough to identify your colleagues here for the record, we will proceed with your statement.

TESTIMONY OF DAVID H. LAW, M.D., DEPUTY ASSISTANT CHIEF MEDICAL DIRECTOR FOR CLINICAL SERVICES, DEPARTMENT OF MEDICINE AND SURGERY, VETERANS' ADMINISTRATION,[1] ACCOMPANIED BY JOHN OGDEN, DIRECTOR-DESIGNATE OF THE PHARMACY SERVICE, VETERANS' ADMINISTRATION CENTRAL OFFICE, AND MACK SISSON, PH.D., INPATIENT PHARMACY DIVISION, VETERANS' ADMINISTRATION CENTRAL OFFICE

Dr. LAW. Thank you, Senator.

On my right is Mr. John Ogden, who is the Director-designate of the Pharmacy Service at the VA Central Office. On my left is Dr. Mack Sisson, who is in charge of the Inpatient Pharmacy Division in the VA Central Office.

Mr. Chairman and members of the Subcommittee, we appreciate the opportunity to appear before you and to discuss the Veterans' Administration Mailout Prescription Program.

Pharmaceuticals or medications are provided by the Veterans' Administration as one component—one very important component—of our comprehensive health care services to eligible veterans. Over the years the VA's Mailout Prescription Program has served as an important adjunct to the total pharmaceutical and health care services offered to our veterans.

Our program offers advantages to both the veteran patient and the health care system itself. Patients avoid waiting times for prescription refills and the necessity to travel to the dispensing pharmacies. For the individual medical center or outpatient clinic, the mailout program allows our pharmacy services to effectively and efficiently manage the use of their staff, their space, and their equipment by permitting the mailout activity during otherwise slack periods.

In fiscal year 1986 the total number of outpatient prescriptions dispensed by VA pharmacies was over 51 million; 28 million prescriptions were delivered through the mail. That is 55 percent of these. The average prescription ingredient cost for the entire 51 million was $6.33 per prescription.

We feel it is important to stress the uniqueness of the VA with regard to this program. The VA's mailout prescription service dispenses prescribed medication from 172 VA medical centers and some 226 outpatient clinics only to entitled veterans who reside within a given medical center or outpatient clinic service area.

The same high quality pharmacy service given to veteran patients who present at the medical center or clinic are provided to all veterans in the Mailout Prescription Program. These services include the maintenance of a computerized individual patient medication profile; review by pharmacists of the patient's drug regimen and drug utilization; monitoring of potential drug interactions and inappropriate concurrent drug combinations.

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[1] See p. 192 for Dr. Law's prepared statement.

Other unique features and facets of the VA medical Mailout Prescription Program are: Prescribed medications are dispensed free of charge as a continuous aspect of the comprehensive health care system provided; secondly, the VA mandates and priority require the Mailout Prescription Program to be cost efficient, accountable, and capable to prevent fraud and reduce or minimize waste; the VA normally dispenses only a 30-day supply of medication with refills as provided as appropriate, up to 5; at least every 6 months, or sooner if indicated, the patient's medication regimen is reassessed by a physician.

The average medication ingredient cost of mailout prescriptions has been found to be significantly less than the private sector, according to the General Accounting Office and reports of the VA Inspector General. The 1983 GAO direction to reduce fee basis prescriptions to 5 percent of the total number is evidence of that GAO finding.

Each VAMC or medical center has a Pharmacy and Therapeutics Committee which is comprised of pharmacists, physicians, nurses, and other health care workers in that facility which establishes local policy and procedures which include the development of a drug formulary to ensure cost effectiveness and quality of drug use, and to review mailout activity as part of the overall review of pharmacy services in that facility. Only routine medications are delivered through regular mail. Controlled substances prescriptions are mailed with a return receipt requested.

A recent random survey by the VA Central Office Pharmacy Service of five selected VA medical centers indicated this past week that the overall Mailout Prescription Program is described by the chiefs of pharmacy service to be rated as good to excellent.

Less than one to two valid complaints occurred out of an average of 918 mailout prescriptions per day per facility. Almost all of these complaints were related to timeliness of receiving the medications. For example, a late request by the veteran patient; postal delays on holidays and long weekend delivery; special requests or more than 30-day supplies of medication, for example, as are provided when a patient is leaving the area to go on vacation; or failure to receive the prescriptions that were mailed.

We have continuing efforts to improve our Mailout Prescription Program. These are in the areas of timeliness of service, development of more efficient computer software, and automatic dispensing systems.

In conclusion, we would like to thank you for your continued interest in the Veterans' Administration and in allowing us to share with you information about our Mailout Prescription Program. We have tried to address your inquiries in the submitted testimony and my staff and I will be glad to answer, or try to answer, any questions concerning the operation of the program.

Senator SASSER. Thank you very much, Dr. Law.

There are a few questions that come to mind. You indicated that the Veterans' Administration pharmacy service did a recent random survey of the VA medical centers. How frequently are such surveys made by the Veterans' Administration?

Dr. **Law**. Dr. Sisson, do you know the frequency of such surveys?

Dr. **Sisson**. Usually the local facility does their own review as a control of what is happening locally. We do not necessarily get involved nationally here in Central Office. But the quality assurance and quality controls are maintained locally.

Senator **Sasser**. In the operation of the VA pharmacies, on the average, with what frequency per hour would VA pharmacists fill prescriptions? In other words, how many prescriptions would your pharmacists fill an hour? Do you have any sense of that?

Dr. **Sisson**. We do not, and the reason for that is that prescriptions by type—if they are a refill request, that may be a prepackaged medication and can obviously be filled in a very short period of time of just removing a label, or a three-part label and attaching it to the container, versus one that has to be counted individually or one that has to be compounded. But our intent is to provide a quality of care for all prescriptions being received.

Senator **Sasser**. Well, could you express any opinion as to the maximum number of prescriptions or rate at which prescriptions could be safely filled? We have heard testimony here yesterday of systems in which pharmacists were required to check 54 prescriptions per hour, for example. To the layman, that would appear excessive, but perhaps not.

What is the rate at which prescriptions could be filled or checked per hour, in the view of the VA?

Dr. **Law**. John, do you have a comment?

Mr. **Ogden**. Well, I think, Senator, it is an idiosyncracy that varies between places in the country. For us—I am speaking particularly of the Veterans' Administration—it also depends on the design of your pharmacy, the work flow design in the outpatient pharmacy; so again, those characteristics would have to be taken into account and for me to tell you a number would not be appropriate or fair because of those idiosyncracies.

Senator **Sasser**. Well, are your pharmacists required to fill a certain number of prescriptions per hour?

Mr. **Ogden**. We have a performance management system in the Veterans Administration and there is no, to my knowledge—and again, I am the pharmacy director designate just coming in from having been out in operations for the Department of Medicine and Surgery for the last 5 years—so to my knowledge there is no set standard per hour or per day for pharmacists to fill.

I do know in the performance management systems, there are places across our system that the operation of the outpatient pharmacy, in regards to that kind of issue, is taken into consideration. But again, it is a local determination.

Dr. **Law**. May I comment, Senator, that this is only one, as I am sure you are aware, small aspect of the pharmacist's duties and the pharmacists within the VA medical centers are not assigned solely to prescription filling. Many of their activities have to do with patient education, with counseling, with quality control and assurance issues, and I think, depending on what a particular activity was assigned to that pharmacist at a particular time of a particular day, you would come up with different numbers.

It would be one thing to assign a pharmacist to do nothing but fill prescriptions during the course of the day. The Veterans' Administration does not do that. That is an important aspect, but one small aspect of the overall responsibility of the pharmacy service within VA centers.

Senator SASSER. Does the Veterans' Administration, Dr. Law, use non-pharmacist technicians in filling of VA mail order prescriptions?

Dr. LAW. Yes, they do, under specific guidelines.

Mack, do you have the specifics, or the supervision of those?

Dr. SISSON. A prescription being filled will be reviewed by a pharmacist prior to filling and also prior to dispensing. The actual support or technician functions in between, as long as it is not a dispensing procedure, can be done by support personnel. The main thing is we do not have technicians filling prescriptions without a review by a pharmacist prior to being dispensed to the patient.

Senator SASSER. In other words, the Veterans' Administration has a pharmacist who reads the prescription when it comes in; is that a fair statement?

Dr. SISSON. Yes.

Senator SASSER. And then it may be filled by a technician?

Dr. SISSON. Under certain controls, yes.

Senator SASSER. And then a pharmacist would check the prescription before it goes out? Say yes or no. The reporter has a tough time getting head nods occasionally.

Dr. SISSON. Yes.

Senator SASSER. So the VA works a system where you have a pharmacist that reads the prescription and then the pharmacist may or may not handoff the order to a technician to be filled. But before the prescription goes out the door, or the medication goes out the door, a pharmacist checks it; is that correct?

Dr. LAW. Yes, and there is more to it than that. When the prescription is read, that prescription is compared to the patient's computerized profile. It is inspected for duplication. It is evaluated for inconsistencies or incompatibilities with other medications that the patient is on.

If indicated, educational or counseling data would be included, and the vast bulk of all of our patients who receive mailout prescriptions initially are seen by a pharmacist. As I say, the VA is somewhat unique in that our mailout program is a composite of 172 hospital and 226 outpatient clinic individual mailout programs, and the medications which are mailed out are mailed to the primary patient care jurisdiction—the local jurisdiction—of that individual hospital and clinic.

So the mailout is really a mailout from the local facility to its own patient.

Senator SASSER. So you have another check at the local facility then; is that a fair statement?

Dr. LAW. Several of them, yes.

Senator SASSER. Now, we have established that the Veterans' Administration does not employ any sort of quota system. As a matter of fact, you do not actually have records of how many prescriptions per hour a pharmacist would fill; is that correct?

Dr. SISSON. Senator, locally there may be performance standards set. They are not set from a centralized point of view, meaning from here in Washington. So they may have standards in place and you might find locations that have established such. But these would only be a guidelines from our point of view.

Senator SASSER. Well, Dr. Law, I will ask you and your colleagues if you would kindly make a review of the Veterans Administration local facilities and give us a typical profile of what performance might be expected, if performance standards are set, for the number of prescriptions that a pharmacist might be required to check before they are mailed out.

Dr. LAW. We shall. Again, just to clarify that, this would be at a time when a pharmacist was given that responsibility, because the responsibility over the course of a week, or even a day, would vary, depending on whether that pharmacist had a significant amount of counseling duty, quality assurance activities, et cetera; so at that time when his responsibility is specifically completing prescriptions.

[Subsequently the Veterans' Administration provided the following information:]

Concerning performance requirements for VA pharmacists for the number of mail-out prescriptions that a pharmacist might be expected to check per hour, the following data represents information from 20 VA Medical Centers: Ten facilities reported no written standard. Ten facilities reported written standards; these standards represented a range from 30 to 160 mail-out prescriptions checked per hour per pharmacist.

We attribute the range to differences in physical layouts of the pharmacies and varying degrees of usage of commercial as well as facility prepackaged medications. It should also be noted that the lower end of the range indicates a number expected for a lengthly segment of duty, for example; 4 hours or an entire 7.5 hour shift. The higher number generally refers to a shorter seqment of duty, for example, 1-2 hours.

Senator SASSER. Now, how automated is the system at the Veterans' Administration for dispensing drugs? How would your automation system compare with some of the major private mail service pharmacies? Or is it automated?

Dr. SISSON. Are you referring to automation as far as the actual filling of prescriptions, or in the ADP processing of paperwork?

Senator SASSER. Well, things like a baker machine that we have heard referred to here in previous testimony, where you press a button and this machine will dispense the appropriate medication.

Dr. SISSON. I think it is a standard procedure of operation to have various types of automated equipment: individual counting systems or baker automated equipment; unit of use packaging, where we have had standardized products. By unit of use being a 30-day supply program, medication that already comes prepackaged, pre-labeled with a three-part label that we can attach a copy and a control number to the prescription or the filling document, is also another way that we prefer as automation, being that we do not spend the time in repackaging.

But I would have to say that all of our facilities are using some type of automated equipment, including our satellite outpatient clinics.

Senator SASSER. Now, I think, Dr. Law, in your direct statement you mentioned something about VA customer complaints. How many of the complaints with regard to your mail order drug operation, relate to actual errors in the filling of prescriptions? By that I mean sending the wrong medication or the improper strength of medication to a particular patient.

Dr. LAW. Dr. Sisson, you have got that data there. Why don't you just read it.

Dr. SISSON. Of the five facilities that we looked at, one had two in 1 month, but their yearly total is over 400,000 prescriptions. Of that, 204,000 were mail, and that was a large outpatient clinic.

Another facility had two reported in 1986—two errors associated with the type that you are describing.

Senator SASSER. Two errors out of how many prescriptions mailed?

Dr. SISSON. 395,000 plus for the year 1986—right around that. Those are documented errors that were complaints that came back.

Senator SASSER. Now, you fill prescriptions on a 30-day basis; is not that correct?

Dr. SISSON. Correct.

Senator SASSER. Now, some of the other mail order companies will fill on a 90-day basis for their customers. What is the view of the Veterans' Administration on this policy? Is it wise to have a 90-day refill policy or not?

Dr. LAW. Well, for the Veterans' Administration it is felt wise to have a 30-day policy for several reasons. One, there is a tendency with a shorter prescription to reduce waste. There is an ability with a shorter prescription to be more cost efficient. It avoids stockpiling of medications and, of course, the Veterans' Administration is a not-for-profit organization and our concerns are less with the actual costs generation and more with costs saved, and so for us, the 30-day prescription is more efficient.

Senator SASSER. When you get a complaint similar to the ones that we were discussing earlier in which the wrong medication is sent to a customer, a patient, or improper dosage is sent, what procedures does the Veterans' Administration follow in responding to such a complaint? First, in responding to the complaint from the complainant and then what procedures are followed to ensure that the error does not occur in the future?

Mr. OGDEN. Well, obviously, we would regret that the error ever happened.

But to answer the first part of your question, when a call would come from a veteran family or from the patient or a letter would be written—again, usually those letters are written to the local hospital, sometimes they might appear on your desk from one of your constituents—we would do a review, investigation, if you will, of that particular incident and try to ascertain if there was some problem in our work flow processing that contributed to that error. If it was a case of an individual pharmacist failure, we would certainly deal with that on an individual basis.

So our mailout program is a convenience, as Dr. Law mentioned in the testimony. Veteran patients like it because, for example, take a State like New Mexico, which has one VA medical center. Some of those veterans live a long way away and it is a convenience. And with our automated system, it allows a veteran to submit a request, even if it is early, and it will be cycled in by the computer and automatically dropped out prior to the time the patient would need it.

That helps us assure quality of care and continuity of service for the veteran.

Dr. LAW. I would like to go back to your comment about what happens with an error, if you will.

Dr. Sisson would like to make a few comments on that as well. There are two other aspects of that.

Dr. SISSON. First of all, if we do have a medication error that is reported back to the facility, there is a quality assurance coordinator locally that reviews that and will also make a report of contact for such. That probably has occurred more now in the last couple of years since we have been putting more efforts into the quality assurance program activity.

Prior to that, they were handled individually as they occurred in the pharmacy service. If there was a complaint about receipt of medication or potential errors, they were handled locally through the pharmacy service and found out as to how they occurred. But they are now documented locally.

Senator SASSER. Now, I note that it is VA policy for every 6 months to require that the patient discuss his medication regimen with his physician. What is the reason for that, Dr. Law?

Dr. LAW. Well, it is thought that of as a quality assurance matter, on the one hand; that it is not advisable to receive medications even with chronic medications without being seen—you could choose a year, you could choose 3 months. But 6 months is a time chosen. Patients conditions change and a responsible physician is going to see his patient, even on chronic medications. The vast bulk of people, of course, are seen before the 6-month period and these reviews are tied in with their follow-up visits to their physician.

In the VA system, the automated data processing program that is underway now presents to the physician an outline of the entire medication profile that a patient is on at the time that he appears in the clinic so the physician can call forth that profile and evaluate what medications the patient is on—all of the medications, whether he has put that patient on it or another physician in the hospital has prescribed it for the patient, and 6 months is an arbitrary time set for this review.

Senator SASSER. Well, gentlemen, thank you very much for appearing here this morning. If we have additional questions, we will forward them to you in writing, and Dr. Law, I would appreciate you and your colleagues giving us a timely response, which I am sure you will do.

Thank you very much.

Dr. LAW. Thank you for the opportunity.

Senator SASSER. Our next group of witnesses will be a panel consisting of Mr. Robert Waspe, representing the National Association of Mail Service Pharmacies, and Mr. Dennis Santo, representing the Thrift Express Pharmacy, a division of J.C. Penney Co.

Gentlemen, if you would, please be kind enough to come forward.

Mr. Waspe, I want to welcome you here this morning, and also you, Mr. Santo. We look forward to your testimony.

Mr. Waspe, if you are prepared, we will begin first with you, if that is convenient.

TESTIMONY OF ROBERT WASPE, NATIONAL ASSOCIATION OF MAIL SERVICE PHARMACIES;[1] AND DENNIS SANTO, THRIFT EXPRESS PHARMACY, A DIVISION OF J.C. PENNEY CO., INC.[2]

Mr. **Waspe**. Thank you very much, Senator.

My name is Robert Waspe. I am an attorney and I am employed by Thrift Drug Company, a division of J.C. Penney Co., Inc., and its Express Pharmacy Services. I am also, incidentally Senator, a 10-year beneficiary of the Veterans' Administration mail order pharmacy program. In those 10 years I personally have never experienced a dispensing error. However, I do have a complaint.

Senator **Sasser**. Well voice it now. This is the time to speak.

Mr. **Waspe**. I personally would appreciate it if the Veterans' Administration would let me get my prescriptions on 90-day refills. It is an inconvenience to have to reorder them every 30 days.

I am pleased to be here today to represent the National Association of Mail Service Pharmacies and to present the Association's statement in response to your written invitation and list of particulars.

I would request the opportunity for our member companies to submit additional written materials in response to testimony given here.

Senator **Sasser**. I might say, Mr. Waspe, that the record will be held open for 2 weeks from today, so they will have the opportunity to make those submissions.

Mr. **Waspe**. We appreciate that very much, Senator.

The National Association of Mail Service Pharmacies represents and promotes the general interest of mail service pharmacies and the consumers they serve. NAMSP was established in 1976. All members must maintain pharmacy licensees in good standing in every State in which they operate a dispensing facility, and all members must have dispensed at least 100,000 prescriptions per year by mail for at least 2 years prior to becoming eligible for membership.

Its members currently include the major mail service pharmacies in the United States: the AARP Pharmacy Service, America's Pharmacy, Health Care Services, Medco Containment Services, Pharmacy Management Services, Baxter Prescription Services [a division of Baxter-Travenol], Thrift Express Pharmacy Services, and Walgreens C.P.O.

I would like to state at the outset, Senator, that NAMSP and its member companies share your concern for the safety and soundness of all prescription dispensing programs, including mail order.

Mail service delivery of prescription drugs has existed since before the invention of the automobile. Rural Americans often depended on their letter carrier to deliver their medications from the drugstore to a distant town. In the early decades of this century, right up until today, both consumers and druggist themselves have relied on the mail or common carriers to deliver prescription medication, either to their homes or their drugstores, respectively.

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[1] See p. 197 for Mr. Waspe's prepared statement.

[2] See p. 219 for Mr. Santo's prepared statement.

NAMSP member companies dispense approximately 20 million prescriptions a year which are delivered by mail or common carrier. However, together, the VA and all private mail service pharmacies' volume account for only 4 percent of the $21 billion U.S. prescription market.

Mail service pharmacies are extensively regulated. Like every operating community pharmacy in the United States, mail service pharmacies are fully licensed and fully approved by the Boards of Pharmacy of the States in which they are located. Like all pharmacies, they must fully comply with the State pharmacy laws and regulations of their resident States. Like all pharmacies in America, mail service pharmacies are registered with the U.S. Department of Justice and must fully comply with the statutes and regulations of the Food and Drug Administration and the Drug Enforcement Administration, specifically in the latter case, with the Drug Abuse Prevention and Controlled Substances Act of 1970.

I would like to note, Senator, that yesterday a witness alleged that mail order operates completely without regulation and is only controllable through litigation. This is a complete misstatement of fact. In short, mail service pharmacies must comply with the same regulations governing security, inventory, storage, record keeping, the proper use of licensed and support personnel, generic substitution, and the dispensing of controlled substances, as any other pharmacy located in the same State.

Mail service pharmacies employ only fully licensed and fully approved pharmacists in their facilities and, of course, like any other pharmacy, mail service pharmacies are subject to inspections and disciplinary actions by their respective State Boards of Pharmacy and the DEA.

Competitors of mail service pharmacy have endorsed and initiated both regulatory and legislative attempts on a State-by-State basis which have as a goal the proposition that a mail service pharmacy should be licensed in and subject to the laws and regulations of every State in which it has a patient. To date, only five jurisdictions have adopted such a requirement. However, each jurisdiction has been reluctant to attempt to enforce these licensure requirements because of severe constitutional infirmities under the commerce clause.

Mail service pharmacies have taken the position that restrictions against the free flow of interstate commerce require them only to be licensed in the States where they are located. To date, many Attorney Generals who have reviewed the issue are in agreement. Indeed, one Attorney General who had previously ruled that licensing of an out-of-State pharmacy was constitutional, subsequently refused to prosecute because the relevant board of pharmacy could not provide any evidence that out-of-State pharmacies endanger the public health.

We would add that the California Board of Pharmacy, after an 18-month inquiry into the alleged dangers of mail service pharmacy, concluded in October, 1986, that there was no credible evidence to support the position that mail service pharmacies either in-State or out-of-State, constituted a threat to the public health and safety. This is precisely the same conclusion reached by every other official investigation conducted on mail service pharmacy, including studies by the FTC and the DEA.

NAMSP is an association of companies engaged in mail service pharmacy. Naturally, each company competes. As such, NAMSP is not privy to proprietary procedures, systems designs, software, hardware or other such information. Such information is the property of each company. NAMSP member companies all practice team pharmacy.

NAMSP company dispensing pharmacists do not sell beach balls or fertilizer, stock shelves, intake inventory, ring the cash register, or deal with salesmen. NAMSP company pharmacists are dedicated to discreet functions within the dispensing process. Typically, one group of pharmacists validate and verify prescription orders. Other groups take telephone prescriptions or call physicians to clarify medication orders. Other dedicated pharmacists answer patient questions about their medications.

Others deal with salesmen or supervise either data entry personnel or technicians working in prepack units. Other pharmacists dispense prescriptions only for controlled substances. But most important, those who dispense only dispense. Support personnel or pharmacy technicians are employed, consistent with relevant State pharmacy law guidelines.

Yesterday it was asserted that some mail order companies employ 50 or even 100 technicians for each pharmacist. That is a total fabrication. In nearly every United States jurisdiction, only licensed pharmacists or pharmacists interns—those pharmacy students in an accredited pharmacy program—under the direct supervision of a licensed pharmacist, may dispense a legend drug.

The use of conveyor belts, moving files and computerized record keeping greatly increase productivity. While we are advised that no company has established productivity quotas, we understand that all companies have normal business expectations about productivity, guided by the paramount consideration that productivity cannot interfere with accuracy or professional judgment.

Every NAMSP pharmacy has established extensive quality assurance checks and balances within its respective dispensing process. We understand that in no case is a new prescription reviewed by fewer than two pharmacists. In most case, we are told that three or more pharmacists will review a prescription before it is shipped.

Every NAMSP pharmacy maintains computerized patient profiles which accurately and instantaneously can recall each and every drug, prescriber, dosage strength, authorized refills, refills dispensed, et cetera. These profiles enable the pharmacies to maintain sophisticated proprietary drug interaction software to ensure that all drugs dispensed by the pharmacy to the individual patient are not contraindicated. When patients provide information about their allergies, this information is also added to the drug interaction profile. At data entry, all prescriptions must clear the interaction screen before a label can be printed and the prescription sent to a dispensing pharmacist.

Such quality assurances are augmented by verifying the prescriber's DEA number on each prescription. This is accomplished by an on-line check of the number itself and, if necessary, use of the American Medical Directory. When the prescription order reaches a dispensing pharmacist, supplementary warning labels are added where indicated. For example, warnings against operating a vehicle or drinking alcoholic beverages.

Additionally, NAMSP member companies often supplement the labeling information with additional patient consultation information, including the name of the drug, the condition for which it is prescribed, how to take it, how to store it, what to do if a dose is missed, possible side effects, and what to do if the side effects or adverse reaction occur.

All NAMSP member companies provide toll free 800 number telephone service so that patients have easy access to a pharmacist within the facility who has readily retrievable access to patient records in order to answer questions. This toll free service is provided during all working hours, and by several companies, at least 6 days a week.

All NAMSP companies have strict inventory controls, purchasing their inventories primarily through recognized national primary wholesalers or directly from the manufacturers. All inventory is checked at receiving for damage, expiration date, strength, supply and drug code number. Because most NAMSP companies turn their inventories 12 to 20 times a year, outdated drugs are rarely a problem. In most cases, any product received in a factory container whose expiration date is within 6 months of delivery is not accepted.

Most stock, I would note, has a remaining shelf life in mail order pharmacies of 5 years. Most, if not all, NAMSP companies prepack their fastest moving inventory within their respective facilities. Under careful supervision of licensed pharmacists, support personnel break larger supply factory containers of high velocity products and prepack them into the most frequently prescribed quantities. Such prepacked products are bar-coded to track them to the original factory containers in the event of a manufacturer's or regulatory authority's recall order.

Security against drug diversion is of critical importance to NAMSP members. Prescriptions for controlled substances are dispensed in separate and secure controlled substance cages or rooms. All such controlled substances rooms meet or exceed Federal and State physical security requirements. Most are equipped with both motion and infrared sensors. As noted earlier, all prescriber orders for controlled substances are verified by a check of the prescriber's unique DEA number supplemented with random checks of telephone numbers, addresses and knowledge of patient identities.

NAMSP member companies also package prescriptions under separate secure conditions and nothing on the exterior of the package indicates in any way the identify of the contents, regardless of whether or not it contains a controlled substance. Moreover, DEA and postal regulations governing the shipment of both controlled and non-controlled substances are rigidly obeyed.

NAMSP companies employ a number of procedures designed to protect sensitive products from exposure to extremes of temperature. Some companies will not ship certain products like insulin to certain areas in specific months of the year. Others will not ship on specific days. Others ship temperature-sensitive products in specially designed styrofoam cool-packs supplemented by additional packaging insulation.

However, all NAMSP companies' packaging specifications meet or exceed the specifications of the manufacturer who, after all, ship the same products by common or private carrier to community and mail service pharmacies alike. Temperature sensitive products which are shipped routinely require a signature upon receipt at the point of delivery.

Because millions and millions of prescriptions are dispensed annually by human beings, errors are bound to occur. Such errors are made either through omission or commission and they occur in all practice settings, whether institutional, community or mail service. Regardless of the practice setting, dispensing errors are made and no pharmacist can be proud of having made them.

However, we are aware of no major study or evidence that compares the respective error rates of the major practice settings. Certainly, there is no evidence that an error made in a mail service setting has anything intrinsically to do with mail service pharmacy. We believe that the quality assurance procedures instituted in the NAMSP member companies have contributed more to prescription accuracy than in any other practice setting.

One member company reported 73 errors of any nature out of 1.5 million prescriptions shipped in 1986. Another member company reported its insurer's analysis at one error every 385,000 prescriptions shipped.

Do errors occur? Yes, absolutely. Do we catch them within the facilities due to our procedures? Yes, in almost every case. Very few ever reach a patient's hands. Do we aspire to 100 percent accuracy? Absolutely.

The Subcommittee should also take into consideration the intense scrutiny under which NAMSP member companies must operate in filing prescriptions under major medical plans. Because the medical directors of those plans are obligated to pay for beneficiaries' hospital and physician expenses, they cannot afford to look the other way if second rate pharmacy is being practiced. In short, NAMSP members operate under greater scrutiny than most community pharmacies.

NAMSP member companies are ready and willing to have their accuracy record compared with those of any other practice setting. A revealing indicator of accuracy and professionalism would be the disciplinary proceedings of the boards of pharmacy in the States where mail service pharmacies are located. Ask those boards to tell the Subcommittee which practice setting generates the largest number of complaints, either in absolute numbers or relative to the volume of prescriptions dispensed. It will not be mail service pharmacy.

By way of example, one of our member companies conducted an informal study of complaints in a State where three NAMSP member companies have facilities. During the period 1979 to 1985, when mail service pharmacy was experiencing rapid growth, nearly 9,800 complaints were filed with the Board of Pharmacy against pharmacists or pharmacies. Of those 9,800 complaints, only 4 could be attributed to mail service pharmacy.

To close, Mr. Chairman, we gratefully acknowledge your willingness to invite us to appear before you and your colleagues and offer our comments on how we practice pharmacy. For years and years our competitors have attempted before legislative and regulatory bodies to make mail service pharmacy a less competitive alternative to community pharmacy. To our patients credit and benefit, these have, for the most part, failed.

We ask you, should consumers or independent retail druggists determine which pharmacy services are available to the general public?

In addition to the Association's statement, individual NAMSP member companies have and will submit written statements for the record.

I thank you, Senator.

Senator SASSER. Thank you, Mr. Waspe.

We will now hear from Mr. Santo.

Mr. SANTO. Thank you, Mr. Chairman.

As a way of introduction, I am the vice president of pharmacy services for Thrift Drug Co., and as such, my responsibilities are to oversee the daily activity of Express Pharmacy Services, our mail order department.

I have been a registered pharmacist for the last 29 years and based on what I heard here yesterday, it appears to me that I probably have one of the most diverse backgrounds of anyone to appear before this Subcommittee. For the first 10 years of my professional career I worked in community retail pharmacies. The second 10 years I managed two very large drugstores for Thrift Drug Company, and over the last 9 years I have had varied management responsibilities at the corporate level in Pittsburgh.

Senator, we too share your concern for the betterment of the health and welfare of our citizens. Let me spend a few moments explaining our methodology and operation and perhaps we can overcome your concerns that yesterday's testimonies might be commonplace. I assure you that from our point of view, you heard from only a minute portion of this growing industry.

Thrift Drug Co., a division of J.C. Penney, deeply appreciates the opportunity to testify here today. Our company was founded in 1935 by two Pennsylvania pharmacists with a commitment to service, quality and reasonable pricing. Thrift Drug opened its first store in Sewickley, PA. Today we operate more than 400 retail outlets in 18 States and we are guided by a management team that maintains the same commitment to customer service, quality products and performance as our early founders.

In 1969, Thrift Drug became a division of the J.C. Penney Co., the third largest retailer in the country. J.C. Penney is a Fortune 100 company with over $14 billion in annual sales. Throughout Thrift's 52-year history, the company has emphasized its prescription business, which still accounts for more than 40 percent of our total sales.

Thrift Drug employs more than 1,100 registered pharmacists and dispenses over 20 million prescriptions annually. Thrift Drug operates Express Pharmacy Services [EPS], a mail order pharmacy which was established in January 1983 in Pittsburgh. From a zero base of business that year, EPS has grown to four facilities and filled over 1.5 million prescriptions in 1986. Current projections show that EPS will fill over 2.2 million prescriptions in 1987. I might add that these mail order facilities are required to meet all the same requirements for State licensure as any other retail establishment in that State.

Created in a response to the need to contain and reduce rising prescription costs, EPS supplies maintenance prescriptions—those taken regularly on a long-term basis—by first class mail or UPS to members of groups and corporations nationwide. Thrift's mail order history began in 1983. Our first facility, located in Pittsburgh, serviced the Pennsylvania State Employees Health and Welfare Fund, our first account.

As one of the first chain companies to enter the mail order prescription business, Thrift was a pioneer in this new health delivery field. Supported by Thrift's chain-wide computerized pharmacy system, we were well prepared to offer the new service. A turning point came in 1984 when agreements with a number of corporate clients created substantial volume, and as business expanded, new facilities were needed.

Currently we operate four facilities—two in Pittsburgh and one in Philadelphia, PA, and a fourth in Birmingham, AL. Today, EPS services nearly 300 companies, emphasizing the following: cost savings, generic substitution, controlled dispensing, client service, and quality control.

Savings accrue from a sponsor-negotiated source of supply for both the participant and the employer. EPS, through its economies of scale, can provide lower cost dispensing of prescriptions by centralizing the prescription dispensing function. Administrative costs are also reduced through centralized billing and payment procedures. One statement is sent to each company every month and only one check must be issued, as opposed to the customary numerous claims that may be required should coverage be offered through a retail program.

Whenever possible and permissible by law; EPS maximizes the substitution of bio-equivalent generic drugs in place of the more expensive brand names. There is a 50 to 80 percent savings which results when generics are dispensed versus brand products. EPS uses one of the leading generic distributors as a single-source supplier in order to provide a product which is consistent in color, shape and therapeutic effect.

Thrift Drug Co. developed its own computerized pharmacy system for use in its retail stores as well as EPS facilities. This online system is known as "Rxtra." Through the Rxtra system, Thrift and EPS pharmacists can identify potential drug-to-drug interactions, drug-to-allergy problems, and drug-to-health condition idiosyncracies.

Thrift and EPS retains as a consultant a doctor of pharmacology from the School of Pharmacy at Duquesne University, located in Pittsburgh. He updates all information regarding these drug interactions. The Rxtra system provides for eligibility verification each time a prescription order is received by EPS. This prevents the unauthorized use of the plan. The system also monitors and controls refill authorizations.

Computerized plan parameters are entered into the system, which prevent refills from being dispensed before a certain percentage of the previously dispensed prescriptions have been consumed. This methodology eliminates the potential for stockpiling.

EPS's planned parameters provide for a maximum of 90-day's supply of medication. EPS provides a professional installation team to ensure a smooth initiation of home delivery prescription service. An announcement kit and operations manual are customized by EPS and are given to each eligible member of the company or organization.

EPS provides for functional servicing of every client account by providing direct access to a responsible servicing representative at Thrift Drug's headquarters. Each EPS facility has at least 12 toll free 800 telephone lines, which allow personal consultation with the pharmacist, placement of refill orders, and price inquiries. An unlisted toll free 800 telephone number is provided to physicians for immediate response to prescription inquiries and consultations.

Each participant is given a postage-paid order form initially and a postage-paid reorder envelope with each prescription dispensed. Prescriptions are delivered via first class mail or by United Parcel Service. These features promote plan utilization and help for the employer and the participant to save money. For all the consumer concerns mentioned yesterday by the Retail Druggists Association, our industry has hundreds of testimonials from satisfied and grateful consumers.

Each prescription is filled by a registered pharmacist—and pharmacist only—in our facilities. Every prescription is reviewed by this registered pharmacist for potential drug interactions, using the Rxtra on-line pharmacy system. Also, every prescription is reviewed and checked by a different registered pharmacist in a separate quality control area.

Let me repeat—every prescription is reviewed and checked by a different registered pharmacist in a separate quality control area. Some of the checkpoints are, first, to determine if all the written information on the prescription label is correct, including directions for use, refill authorizations and auxiliary labeling.

Second, a visible inspection of the drug product dispensed is conducted.

Third, the pharmacist initials the hard copy of the prescription which moves with the order as it proceeds through each section as verification of the double checking process.

These are only a few of the items reviewed in our quality control area. It is at this section that Patient Advisory Leaflets—we refer to them as PAL's—are included in the order. These PAL's explain facts about the prescriptions being dispensed in easy to read laymen's language.

These quality control features give our patients and corporate clients comfort and confidence in Express Pharmacy Services. EPS provides for associate accountability in every step of the prescription filling process. This is our assurance of company-wide quality service to all our patients and sponsors.

EPS provides for drug-batch monitoring for all medications dispensed from our state-of-the-art counting machines—baker automated dispensing units. Each time one of these dispensing units is refilled with product, the date, lot number and expiration date from the stock bottle and the associate's identifier is entered on a log-card. This filling is verified and the log-card initialed by a second pharmacist prior to any dispensing of this medication.

In the unlikely event of a manufacturer's recall, EPS can provide a print-out of all patients who have had prescriptions filled from this recalled lot number. All packages mailed to our customers provide for confidentiality through a nondescript mailing label. Every package is either heat or adhesively sealed to provide for tamper-resistant precautions.

EPS is currently investigating tamper-proof seals to be attached to each vial of medication before it is packaged in the tamper-resistant mailers.

EPS also benefits the patients in other ways. EPS can demonstrate and has studied extensively our ability to offer lower overall costs of medications than through retail programs. The economies of scale previously mentioned contribute to the overall savings. Most sponsors have passed on some of these savings to their members by lowering co-pays and reducing deductibles.

The convenience of home delivery is obvious to those limited by disabilities that prevent them from traveling to retail outlets. For those not restricted, the convenience of not having to travel in bad weather and long distances also enhances the home delivery benefit.

Yesterday's witnesses advocated a law requiring licensing in all 50 States by mail order pharmacies. I fail to see how this proposal would alleviate any of the concerns and allegations made yesterday. Fifty licenses will not prevent human error in prescriptions. Fifty licenses will not prevent stockpiling, if that is the intent of the third party participant. Fifty licenses will not make a drug interaction monitoring system any more effective. Its only impact will be to increase the administrative costs, which may ultimately be reflected in higher prescription costs for tens of millions of the citizens across our country.

We deeply appreciate the opportunity to provide this statement to your Subcommittee, and Thrift Drug Company hopes our testimony will be given careful consideration.

I would also at this time like to invite you and any of your Subcommittee members to visit any of our facilities and perhaps, at your leisure, we would consider giving you a tour through each and every one of our facilities if you so desire.

Thank you.

Senator SASSER. Thank you very much, Mr. Santo. A couple of questions occur to me. I am reading here one of your brochures from Express Pharmacy Services. You have on your brochure a statement of what your quality standards are. I note the similar brochure that Senator Heinz was referring to earlier in the hearing from one of your competitors does not have a statement about quality standards on it.

But you indicate that Express Pharmacy Services guarantees that all prescriptions will meet the highest pharmaceutical standards of quality, safety and effectiveness. It goes on to say, each and every prescription is filled and checked by highly qualified registered pharmacists.

Tell us how that is done at Express Pharmacy Services.

Mr. SANTO. Well, firstly, you would have to be able to envision the physical layout of our plant. Our plants are designed so we have—I will use our Pittsburgh plant as an example—12 minipharmacies within Express Pharmacy Services. Each of these minipharmacies has its own computerized pharmacy system. Each is manned by a registered pharmacist and one technical representative. This technical person in our environment is referred to as a "setter" and their responsibility is to retrieve product for the pharmacist.

The pharmacist enters all the prescription information into the computer, including directions, refills, doctor's name, et cetera. He has the physical hard copy of the prescription in his hand when he does that. The Rx setter retrieves the product, either from our baker pill counters or from stock portions of our inventory. He then takes the pre-counted tablets that the Rx setter provides him, visually inspects that that is what he wants, puts it in the prescription vial, and forwards the order bin—the complete order bin—to the quality control section.

Senator SASSER. Does a pharmacist then check it at the quality control section?

Mr. SANTO. When it gets to the quality control section, a separate pharmacist reviews the entire order.

Senator SASSER. So you have a pharmacist who reads the prescription?

Mr. SANTO. Absolutely.

Senator SASSER. And who directs the runner or technician to fetch the drug or medication?

Mr. SANTO. That is correct.

Senator SASSER. Then the pharmacist inspects it and puts it in the container, or inspects it in the container?

Mr. SANTO. That is correct.

Senator SASSER. Then it is forwarded on to another pharmacist who inspects it before it is mailed out?

Mr. SANTO. That is correct.

Senator SASSER. Now, the hard copy travels throughout the entire filling and dispensing process, as I understood your testimony.

Mr. SANTO. Up to and including the quality control; that is correct. The quality control pharmacist removes the hard copy, does all of his physical checks, and then files it in a pigeonhole to be filed by a clerical after the fact.

Senator SASSER. Now, is it just the policy of Express Pharmacy Services to have the hard copy follow the product up to and including the quality control checkpoint? Or is that industry policy to do that?

Mr. SANTO. I cannot answer that, Senator. It is our policy. I have never seen the operational flow of one of our competitors. All I can tell you is what we do and how we do it.

Senator SASSER. How many prescriptions, Mr. Santo, does one pharmacist fill an hour, or check an hour at Express Pharmacy Services?

Mr. SANTO. We have goals of attaining 30 prescriptions per hour. That is one every 2 minutes. Frankly, we are only reaching that in one of our facilities. The reason for that is the maturity of that facility. As was previously mentioned today by the VA representatives, refills take substantially less time than filling a new prescription, and in this mature facility in Pittsburgh, the ration between "news" and refills is reaching such a level that we are getting close to and occasionally meeting our 30 per hour goals. We are not reaching those goals in our other facilities.

Senator SASSER. With regard to the other facilities that are less—to use your terminology—less mature, where there are less refills, do you have any information as to the average number of prescriptions that your pharmacists are checking there?

Mr. SANTO. Somewhere between 25 and 30. We are not reaching 30.

Senator SASSER. Mr. Waspe, do you know of any mail service pharmacies that have been subject to disciplinary actions by the State Boards of Pharmacy or the DEA?

Mr. WASPE. Specifically, Senator, I think in my testimony I indicated that one State Board of Pharmacy, of its 9,800 complaints, four were directed toward mail service pharmacy. Other than that, I have no specific knowledge at this time, but I will be more than happy to develop that information for you.

Senator SASSER. Yes, if you would do that, we would appreciate it.

[The information received follows:]

Although NAMSP is a trade association which represents mail service companies, it does not represent all mail service companies. Moreover, NAMSP does not collect nor compile information concerning actions of State Boards of Pharmacy. That is done by the National Association of Boards of Pharmacy (NABP). It is the NABP which would have statistics concerning the actions taken by state boards of pharmacy against all types of pharmacy practices including mail service pharmacies. I believe it is important that you compare all pharmacy practices including retail druggists, chain drugstores, institutional pharmacies, and mail service pharmacies.

Senator SASSER. What is your opinion of the so-called bonus system in checking prescriptions? I might ask Mr. Santo that question. He is a pharmacist.

Mr. SANTO. Well, obviously, we do not advocate that since we do not have it in our facilities, and we would like to think that we are sensitive to the personnel needs of our employees. Frankly, I think there are too many outside potential distractions to rely strictly on a quota system. That is my personal opinion.

The filling of compounded prescriptions—which surprisingly, we do a substantial number in mail order—takes substantially more time than filling a tablet or capsule-type prescription.

Senator SASSER. Now, for those of us who are not familiar with the profession, a compounded prescription—is that one that you actually have to mix the components of the ultimate end-product there on the spot?

Mr. SANTO. That is where little old men like me know how to do that.

Senator SASSER. But you do not actually take the—what do you call it?

Mr. SANTO. The mortar and pestle. Yes, we do that, sir.

Senator SASSER. I see. Well, no wonder in some of those plants you are not doing the 30 prescriptions per hour if you do that.

Well, in any case, I agree with you. Just from the laymen's standpoint, it appears that the bonus system would not be conducive to placing accuracy and quality above productivity, which I would think would be—in dealing with medications that can be dangerous—would be the highest priority.

Well, gentlemen, I appreciate you appearing here today and giving us the benefit of your views. As I said earlier, we will hold the record open for an additional 2 weeks for any amplification of your statements or any other pertinent material that others might wish to file.

Thank you for being here.

Mr. **Waspe**. Thank you very much, Senator.

Mr. **Santo**. Thank you, Mr. Chairman.

Senator **Sasser**. I want to thank all of our witnesses who appeared before the Subcommittee here today to testify on the subject of safety and soundness in the mail order prescription industry.

As I said earlier, the hearing record will stay open for 2 weeks so that supplementary information can be received from interested parties.

I do believe and am confident that as this hearing record is studied, examined and amplified on, that we will be doing a major service for the American consumer who chooses to receive his or her prescription drugs through the mail. They will, I believe, as a result of this hearing, get a better view of how this industry works, how it is regulated at the Federal and State level, and the types of quality control standards that they can expect when they choose to receive their drugs through the mail.

Furthermore, I believe that this Subcommittee's inquiry will yield other fruits as well. It is clear to me that there are some profound regulatory battles occurring now, especially at the State level, as to how mail order pharmacies are to be regulated. There is also some question as to the type of regulations that might be suitably imposed on mail service pharmacies at the Federal level.

But I think in the final analysis the Federal Government, most especially where it directly or indirectly promotes or enhances the mail service pharmacy concept, has an obligation to the consumer to make sure that he or she does not receive an unsafe or unsound drug. And I am sure that the many industry representatives both today and yesterday will join me in seeing that their industry maintains absolutely the highest possible standards in dispensing prescription drugs through the mail.

The Subcommittee stands adjourned.

[Whereupon, at 12:05 p.m., the Subcommittee adjourned subject to the call of the Chair.]

APPENDIX

A Statement to the

Subcommittee on Governmental Efficiency, Federalism
and the District of Columbia, Senator Sasser, Chairman;

Senate Committee on Governmental Affairs, Senator Glenn, Chairman
by

Keith D. Kellum, R.Ph.
Chairman, Legislative Affairs
Virginia Pharmaceutical Association

Concerning the Dispensing of Medications by Physicians
&
The Filling of Prescriptions by Mail Order

Subcommittee on Governmental Efficiency,
Federalism and the District of Columbia
Senator Jim Sasser, Chairman
United States Senate
Dirksen Senate Office Building
Room 342

Wednesday, August 5, 1987
1:30 P.M.

Enclosures Relevant to Mr. Kellum's Testimony

1. Biography of Keith D. Kellum, R.Ph.
2. Opening Statement on Mail Order Prescriptions - A Convenience to Patients or A Time Bomb for the United States
3. Advantages vs. Disadvantages of Prescriber Dispensing (An Enclosure from the Virginia Pharmaceutical Association Study on Physician Dispensing)
4. Prescribing Errors (A Study Based on a Ten Day Period in 29 Chain Drug Stores)

Keith D. Kellum, R.Ph.

Chairman, Legislative Affairs Committee
Virginia Pharmaceutical Association
2509 Beaufort Avenue
Virginia Beach, Virginia 23455
(W) (804) 464-2941
(H) (804) 464-9595

Keith Kellum, R.Ph., was born in Kansas in 1936; grew up and was educated in Texas (University of Houston School of Pharmacy '67) and is a practicing community pharmacist at Bayside Pharmacy in Virginia Beach. He is also a clinical instructor of Pharmacy and Pharmaceutics in the Medical College of Virginia's preceptor-clerkship program.

For the past seventeen years, Mr. Kellum has been involved in Virginia pharmacy leadership at the state level. He was the Virginia Pharmaceutical Association's Executive Director upon his arrival in Virginia and subsequently took a position with the National Association of Retail Druggists as Director of Association Affairs and Assistant to the Executive Director. In 1977, he moved to the Tidewater area of Virginia where he served two terms each as the President and Treasurer of the Tidewater Pharmaceutical Association. He has been a member of most committees of the Virginia Pharmaceutical Association and of the Council, its governing board. He chaired several of those committees.

He has been the Chairman of the Legislative Affairs Committee since June 1986 and is a state advisor for the American Pharmaceutical Association's Political Action Committee. He has served as a delegate to the Virginia and American Pharmaceutical Association's House of Delegates.

Mr. Kellum has been associated with Bayside Pharmacy for the past ten years. He is married to Kendall Quinton Willis, also a pharmacist, and they reside in Virginia Beach. They are members of Christ Episcopal Church in Eastville. They share hobbies of woodworking, tennis, fishing and gardening.

Mail Order Prescription - A Convenience to Patients
or
A Time Bomb for the United States

Ordering products by mail has been around since colonial days. In rural areas, the absence of retail stores often made the ordering of products by mail a necessity rather than a convenience and, although there are often problems associated with mail order products - the customer not getting what he ordered or not getting anything at all - the practice has increased drastically in the last few years and generally works in a satisfactory manner for consumer hard goods.

In recent years, the filling of prescriptions by mail order has proliferated to an amazing degree and this at the very time that restrictions on community and hospital pharmacies for control of their drug supplies have become a nuisance for those who practice good pharmacy. Most pharmacists, however, put up with the restrictions because they know from whence they come and there is a horror story connected with each law and regulation passed to restrict bona fide practicing pharmacists. The trail of drugs from manufacturer to consumer is very tight - pharmacists who have even a small shortage of controlled substances during their state run drug inspections are routinely very heavily fined and, in some cases, have their licenses to practice suspended or revoked.

In most cases, contrary to the claims of those who practice mail order pharmacy, it takes several days for a patient to receive his or her medicine from the mail order pharmacy and there is no instantly available consultation with a knowledgeable pharmacist. These mail order operations advertise a toll free telephone number that a patient is supposed to be able to call, but, if a patient has never seen the medicine before, there is an above average chance that he or she will not even try to get through to the mail order pharmacy. If the patient tried, there is a good chance that the individual answering the phone will not be able to answer the patient's question without considerable research. In a community pharmacy, that information is readily available and most pharmacists will volunteer information to the patient above what they are required to do by law to make sure the patient knows what can happen if they don't comply with the physician's instructions.

Modern pharmaceuticals can be very dangerous if taken with something which interacts with the drug, which augments its effect, or is incompatible with the patient's age or sex. A pharmacist can fix this instantly in a community, face-to-face setting. It is generally not possible by mail - even if, as some mail order operations claim, they "routinely" contact patients to see is the medicine arrived on time or whether the patient has any questions about the medicine. It sounds good on paper but the practical aspects of doing this make it a virtual certainty that it is not, in fact, done. The pharmacist is the generally conceded expert on drugs. Most state legislatures have written this into law - most state drug codes are enforced by the Board of Pharmacy; and most physicians acknowledge that their local pharmacist has made some "nice saves" by intervening in questionable cases. The classic "accountability" map - who did what to whom and when" is missing from the equation when controlled substances are sent through the mails.

One need only look at the potential for abuse of these controlled substances - there is not even a "return receipt requested" accompanying the medication to ensure that the patient actually even received it. Forged prescriptions are difficult to handle for community pharmacists who generally know nearly all the physicians in their local area and who are alerted to missing prescription pads on their frequent price updates from wholesalers. It would be quite simple for a drug abuser to receive drugs through this type of an operation and his chances of getting apprehended are virtually nil.

Summarizing the objections to Mail Order Pharmacy operations:

1) The classic physician-patient-pharmacist relationship is not present thereby eliminating the all important safety cross-check. This relationship is required by law in Virginia for a prescription to be bona fide.

2) The possibility of the patient's receiving the wrong medication or even someone else's prescription is greatly increased.

3) Direct contact between the patient and the pharmacist who filled the prescription is virtually eliminated.

4) It is very difficult for the patient to get information about the drug - in all community pharmacies, the USP-DI is required to be present and updated under penalty of very severe fines. This is true also of the mail order pharmacies but it is much more unlikely that the patient could easily get the information.

5) According to the Schering Report IX, 86% of patients use the same pharmacy all the time and their pharmacist is very highly respected. The pharmacist has information on allergies, other drugs the patient is receiving from different physicians and even on OTC medications the patients may be taking which could cause medical problems with the prescribed drug.

6) Many times, in Virginia over 1,500 times per day according to a recent study, the prescription results in a "severe" interaction which requires pharmacist intervention with the prescribing physician. Many of these severe interactions could be fatal to the patient such as giving a blood thinner to a patient with an ulcer. No single physician would make this error but, if a patient is seeing multiple physicians, it can happen inadvertantly. A trained pharmacist would detect this on the spot. It may be more difficult for a large mail order house to do so - especially if the prescriptions come in at different times.

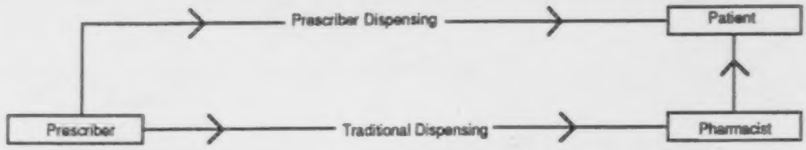
7) The potential for abuse of these controlled substances when delivered through the mail is much higher than in a community or hospital based pharmacy.

8) The accountability trail for error is much less visible than in the classic physician-patient-pharmacist relationship.

In short, the filling of prescriptions by mail order can be dangerous to the public health.

PRESCRIBER DISPENSING: Is It *REALLY* In The Patient's Best Interest?

By Gerald Selph, R.Ph., Mary Rodeffer MCV P'87, and Thomas Rapp MCV P'87



PRESCRIBER DISPENSING

ADVANTAGES

1. Cost saving to the patient. (?) *
2. One stop for the patient. (?)
3. Consultation directly with prescriber. (?)
4. Increases sources of drugs for patient and competitive prices. (?)

DISADVANTAGES

1. Removal of checks and balances by the pharmacist.
2. Tendency to prescribe what is stocked rather than the drug of choice.
3. May tend to increase office visit fees to include the price of the medications.
4. May dispense very large quantities to last between visits or charge office visit fees for refills.
5. Inadequate record keeping and labeling.
6. Total drug therapy profile of patient not seen, as patient may be seeing other doctors also.
7. Probable dispensing by non-professionals without direct supervision.
8. Only limited office hours available for refills.
9. No routine official inspections to ensure compliance with good dispensing practices.
10. Over-prescribing may be a temptation.
11. Drug diversion is much more likely.
12. May actually decrease competition by feeling of pressure from the prescriber.

TRADITIONAL PRESCRIPTION

ADVANTAGES

1. Reinforces drug therapy by double checking strength, dosing schedule, allergies, and drug interactions.
2. Stocks a full inventory of legend and OTC drugs as well as durable medical equipment.
3. Allows for more appropriate prescribing and also for needed compounding of prescriptions.
4. Flexible billing, including charge accounts and third party payment services. Also annual summary of medications for major medical reimbursement.
5. Pharmacy location and hours allow for more convenient refillin of prescriptions as well as filling of emergency prescriptions.
6. Patient counseling will reinforce physicians' directions and increase compliance.
7. Prescriptions can be mailed to less mobile patients.

DISADVANTAGES

1. Possible additional stop and wait for the patient.
2. Possible Rx transcription error through prescribers' agents and pharmacists.

Organizations and individuals that are publicly opposed to Prescriber Dispensing include: American College of Apothecaries; AMA; APhA; Dr. Arnold Relman, editor NEJM; National Association of Chain Drug Stores; NARD; Ron Wyden, House Representative from Oregon; Va. Senator C. A. Holland, MD; VPhA.

Position of AMA House of Delegates, December, 1986:

> "Although there are circumstances in which the physician may ethically engage in the dispensing of drugs, physicians are urged to avoid regular dispensing and retail of drugs, devices or other products when the needs of the patient can be met adequately by local ethical pharmacies or suppliers."

A recent joint statement issued by the AMA with NARD and NACDS said that:

> "Traditional checks and balances provided by a system authorizing physicians to prescribe and pharmacists to dispense prescribed medications best serves the public health and welfare of the consumer."

* Advantages listed for Prescriber Dispensing are not but so likely to be realized, as: (1) charges may well be MORE than at local pharmacies; (2) the patient may need additional medications, adjuncts, or equipment not sold by the prescriber; (3) very often the prescriber is very busy, or the patients feel inadequate to discuss their medications with the prescriber at length; (4) see item 12 under Disadvantages.

Prescribing Errors - Do They Ever Happen?
and
Who Catches the Errors?

by Richard H. Barnes, R.Ph. and Nadjwa G. Durham, MCV P'87

Pharmacists have anecdotal stories by the thousands of potentially disastrous errors they have corrected via a simple telephone conversation with a physician. In many cases, the physician is unaware of medication the patient is receiving from another physician and prescribes a drug which could cause a severe interaction with the other drug - or, in some cases, the drugs will cancel each other out. Anecdotal stories, however, are not what this Board needs to hear.

Since 1984, the Virginia Pharmaceutical Association has run a Therapeutic Drug Utilization Review Program for the Virginia Department of Medical Assistance Services. For the last three years, all Medicaid records have been scrutinized by four regional committees composed of four pharmacists and one physician each. A computerized compilation of a patient's chronological drug regimen often reveals some of the discrepancies referred to anecdotally. Letters are sent *by the hundreds* to physicians and pharmacies for informational purposes as an educational tool for their use as they see fit. The theory is that better communication between physician, patient and pharmacist will result in changes in drug therapy which should reduce *hospitalizations brought about by inappropriate drug therapy.* The program has been very favorably received by the medical community with less than 5% negative responses to the letters. And, in many cases, it is observed upon rechecking the patient after 60 days that the medication was changed for the patient's benefit - even though the physician may have responded negatively or not at all.

By omitting the cross check of the pharmacist from the equation, severe interactions could become commonplace.

Recently, a local drug chain kept records on "moderate to severe interactions" for 29 pharmacies for ten days. A total of 350 moderate to severe reactions were found (See data sheet on the next page). Records from the pharmacy of a major Tidewater Virginia hospital reveal the same thing - except that the majority of these prescriptions could have been fatal to the patient.

Remembering that these are only the moderate to severe interactions (There were literally thousands of minor and other reactions or interactions which, while significant, are not a general threat to the patient) and only represent 29 stores and one hospital, the average was 1.2069 moderate to severe reactions per day per community pharmacy. Extrapolating to the full 1,300 community pharmacies in Virginia, it can be seen that pharmacists intervene in about 1,569 cases per day. Presumably, if the pharmacist were excluded from the health care equation, these interactions would go unnoticed.

Physicians who are also pharmacists are among the most adamant against physician dispensing *because they realize how important the pharmacist's knowledge of drugs is to the physician.* To allow an individual physician to practice pharmacy without the cross check provided by a pharmacist who knows the patient's drug history is *not a wise idea.*

Physicians generally study only one course in pharmacology in medical school and it is generally not the most important course to them. Pharmacists, on the other hand, spend three years studying nothing but pharmacology and are the recognized experts in drugs and drug therapy. There is a place for both in the health care equation and to permit a physician to dispense at will to his patients is tantamount to training Mario Andretti to fix his own race car. He could probably easily learn how to do it and save the mechanic's salary in the process but 1) As the driver, his expertise is in driving, 2) his interest in fixing the car is less than the mechanic's and he will probably not bother to learn all the intricacies of the mechanic's trade and 3) will probably not be either a good driver *or* mechanic.

The raw data referred to are available for any member of the Board of Medicine to review, however, it was provided to this study group as informational in nature and the incidents have been resolved, usually by the pharmacist's calling the physician. Parenthetically, there were several notes attached to the data by the pharmacists that referred to *gross* dosage errors that are not included here.

Drug Interactions Causing Pharmacist Intervention at 29 Chain Drug Stores Over a Ten Day Period

Class of Drug	Number	Per/Day/Store	Virginia
Antibiotics	92	0.3172	412 Reactions/Day
Oral Contraceptives	51	0.1759	229 Reactions/Day
Diuretics	44	0.1517	197 Reactions/Day
Sedative Analgesics	40	0.1379	179 Reactions/Day
Bronchodilators	30	0.1034	134 Reactions/Day
Beta Blockers	22	0.0759	99 Reactions/Day
Miscellaneous	19	0.0655	85 Reactions/Day
Expectorants and Decongestants	13	0.0448	58 Reactions/Day
NSAID	12	0.0414	54 Reactions/Day
Hypoglycemics	7	0.0241	31 Reactions/Day
Antihypertensives	5	0.0172	22 Reactions/Day
H2 Antagonists	5	0.0172	22 Reactions/Day
Antidepressants	3	0.0103	13 Reactions/Day
Anticoagulants	3	0.0103	13 Reactions/Day
Potassium Supplements	2	0.0069	9 Reactions/Day
Steroids	2	0.0069	9 Reactions/Day
Totals	350	1.2069	1,569 Reactions/Day

A total of 350 moderate to severe drug interactions/reactions were resolved by consultation between the pharmacists of the chain drug stores and the patients' physicians during the ten day period. Reduced to a "Per Day Per Store" basis, this equalled 1.2069 moderate to severe interactions/reactions per store per day. Extrapolated over the 1,300 community pharmacies population in Virginia, there were an average of 1,569 resolved interactions in Virginia *each working day. These reactions would probably not have been resolved had the pharmacist not been part of the equation.*

These figures are conservative and do not include interactions picked up by the pharmacist for OTC/vitamin interactions which would probably double the above figures. The figures were obtained solely from the interactions reported on Compute-Rx pharmacy computers which are used in all the stores.

The raw data are available for the Board of Medicine to examine if they so desire on a confidential basis. Based on the sample size, there is a 95% probability that the extrapolated figures are within 5% of the actual occurrences.

Statistics compiled by Nadjwa G. Durham, MCV P'87

5 August, 1987

TO: The United States Senate
Subcommittee on Government Efficiency, Federalism, and the District of Columbia

FROM: Pharmacist-2

In response to the 29 July, 1987 letter from Chairman Jim Sasser of Tennessee, I am willing to submit the following testimony in answer to his questions and will, to the best of my ability, answer in person any questions put to me in public testimony today in Room SD-340.

When a tour group, a prospective client, comes through the plant of National Rx Services Inc. the facility is at it's best. Pharmacists in their long white lab coats are placed throughout the plant, giving the impression that they are overseeing the work in all areas. After the group leaves, the pharmacists wander back to their desks to do what pharmacists do there six or more hours a day. They check prescriptions in bread pans which constantly go by on rotating carousels.

I believe the safety and soundness of pharmacy operations would be much improved if the day to day business was conducted per tour status, that is, in a facility that sends out over 50,000 prescriptions per week, registered pharmacists should be overseeing each area, aiding technicians and clerks there to assure that guesses are not being substituted for good, knowledgeable, professional judgement. Presently there are no pharmacists in the executive and personnel suites, accounting department, purchasing department, mail-opening, the mailroom or warehouse. The head of the customer service is not a pharmacist nor are her customer service representatives. One pharmacist is on duty in that department to manually fill and send out rush orders and to answer technical questions. There are approximately fifteen representatives and the phones ring continuously from 9 a.m. to 8 p.m. EST Computer records are kept on the numbers of calls received and the average amount of time patients have to wait to receive assistance.

Technicians work in the baker cell, the vertical shelves, and the pre-pack filling areas without pharmacist supervision. Their supervisor is not a pharmacist. One pharmacist oversees about twenty technicians who are responsible for the screening process of a prescription, that is, assigning the drug a number code used by the typists and determining how many doses will be sent, how many refills will be allowed, plus deciphering the doctor's directions, at times even a chore for the most seasoned pharmacist. One pharmacist supervises about thirty typists.

Many of these areas could benefit from additional supervision by staff pharmacists. Rotation through the positions on half day shifts would allow the desk bound pharmacists from becoming mentally exhausted robots. The only few hours a week allowed away from desk checking of prescriptions is spent in a doctor calling area , occasionally in the screening area, or collecting returned drugs from other pharmacists. Permanently assigned pharmacists are found in the compounding area, the narcotics area and in the special handling area so these positions are not available to the thirty or more desk pharmacists. A few pharmacists share the drug utilization review responsibilities. Some pharmacists have never had that experience at all even after months at the facility.

The pharmacists' duty of checking prescriptions at National Rx Services is not as clean cut as it is in a retail or hospital setting. The pharmacist never receives the original stock bottle, so tablets and capsules are identified by color, shape or code number, neither a safe or sound practice. In the case of an unmarked white generic tablet one is never sure of what's in the vial so, in that case the ethical pharmacist will leave the desk and check at the source. New products and new generics must be checked in the same way. In my opinion, the company does less than its best in providing proper identification sheets and references for drug identifications.

One of National's selling points to it's prospective clients is the fact that the pharmacists pack at their desks all orders which will fit into two sizes of bubble pack envelopes. Under the best conditions this would be a wonderful idea. However, this allows a hurried, tired, less than ethical pharmacist to send out a less than quality product. In a time saving step, one might not put cotton in the vial or take the time to instruct the patient to take the capsules with water or with orange juice or one hour before meals. This is accomplished by attaching a supplementary label. To save a few minutes, a less than ethical pharmacist may not apply the "generic substitution" label informing the patient that the strange drug name on the vial is indeed the same drug as was written on the prescription in brand name. This, by the way, is not only unethical but illegal. If all filled orders were sent to the mailroom, a quick supervisory check by the chief pharmacist or his assistant would seek out these poor quality dispensing practices.

Why don't all pharmacists at National Rx Services take the time to send out properly labeled, properly packed prescriptions? Why don't some take the time to make sure that the new green generic tablet is the same as the old blue? Why is there not time to write a note to the patient in answer to some questions? In my opinion the lack of quality is the result of the importance of quantity. At National Rx the sign above the entrance to the locker room states, "Quality is Job One". How sad that in truth at National Rx, "Numbers are Job One".

There is a quota system for all technicians, clerks and pharmacists. Productivity is recorded for everyone on a daily and weekly basis. For pharmacists not only how many prescriptions were checked but that number is broken down into how many new and how many refills as a new order takes longer to process. Pharmacists are expected to check at least fifty prescriptions for every hour at the desk. For every one over a weekly total of 2130, a 15¢ per prescription bonus is paid. A highly motivated pharmacist has been known to check over seventy per hour, and working a 60 hour week, as we did in January and February, 1987, the bonus was sustantial, around $300. This same pharmacist recognizing the lunacy of the system, the danger to the patient, and beginning to suffer mentally and physically from the pace, suggested at an April, 1987 pharmacists-only meeting after working hours that we ask management to discontinue the bonus system. All 27 pharmacists in attendance voted in favor. Management would not consider the change.

This quota, numbers-at-any-cost attitude is responsible for screening, typing, filling, checking, and mailing errors. The pharmacist at the desk, to be practicing safely and soundly, should assume that every order is incorrect as it reaches the checking stage and proceed from there. Every kind of error imaginable occurs and has to be caught at the desk by the pharmacist. Wrong drugs, wrong directions, wrong names, wrong addresses, wrong amounts are all mixed in any combination one can fore-see. At one time, mixed drugs or incorrect drugs found in filling areas were announced over the public announcement system as a warning but that practice was long ago discontinued since an outlet was in a public area and such disasters would not sound good to visitors or delivery personnel.

So many mistakes were mailed out to patients during the January-February, 1987 rush that the mistake return area in the customer service department overflowed and a National employee from New Jersey was sent for to sit for days opening and re-cording returned mistakes.

When a wrong drug is received by a patient, customer service hears from the patient via toll-free phone lines. The customer service representative takes and records the information on a "Class A Error Report" sheet, pulls the original prescription from the permanent files and asks the patient to return the wrong medicine to the National Rx facility. The proper prescription is promptly filled and if the patient insists is sent out by overnight delivery. Overnight delivery systems are used on a daily basis at National Rx to replace mistakes or lost or overdue orders. The error report is filed in a cabinet to be joined with the returned medication when it arrives at the plant. Copies of the error report, the original doctor's prescription blank, and the returned mistake are reported and given to the chief pharmacist and those involved in the error are called to his office. Monroe Fauntelroy, the New Jersey based director of all National pharmacies, receives copies of all error reports.

When a wrong drug is caught inside the plant, the drugs are returned to stock and the order re-routed for proper filling. A few pharmacists are assigned to return drugs to stock at the beginning of every work day, without regard to stock number or expiration date, a seemingly illegal operation. In a retail or hospital setting, those unused drugs would not be mixed back into stock but would be set aside the original bottle for first use or easy disposal in the event of a manufacturer's recall. This procedure should be followed at National Rx to insure the safety and soundness of all orders sent out and to comply with pharmacy laws. These return-to-stock vials are considerable in number. Metal cabinets are found in the far-away left back corner of the facility for the storage of the returns until they are again mixed with the regular stock. I once collected these from my fellow pharmacists and at one collection filled a cart and two empty cotton-ball boxes. A fair approximation would be 10 to 20 items per pharmacist per day, about 5%.

A pharmacist at National Rx is not familiar with all the laws of the states to which prescriptions are being sent. A number of the pharmacists are registered in other states and are familiar with the laws of those specific states. However, we are told by management that we are to practice according to the laws of the state indicated on the license which hangs on the wall in the plant to which the pharmacist is assigned. Occasionally, memos are distributed which do take into account the wishes of other states' pharmacy practices. For example, a 10/2/86 memo to pharmacists and technicians from the then chief pharmacist, Don Ivanoff stating that all Class II Controlled Substance prescriptions written by prescribers in New York, Illinois, California, Texas, Idaho, Hawaii and Rhode Island are to be written in triplicate form to be valid. Or, an 11/7/86 memo from supervisors Pat and Tulin to technicians and pharmacists on the subject of prn refills, stating that "all prn refills (except New York) are considered one year from the date the prescription was originally written. New York, the law states "prn" means one refill only". This memo strikes me as strange as other states not mentioned do not recognize prn refills. In addition, we also received a Non-Physican Prescribing Allowed list by state and a listing of drugs which could not be generically substituted for in the state of Florida. However, these lists and memos may be foreign to at least half of the pharmacists at the plant since it was not the practice of management to supply newly hired pharmacists with a folder of old lists and memos.

In regard to generic substitution policies at National Rx: the pharmacist was only to send a generic substitution when the doctor did not dis-allow by indicating his wishes on the face of the prescription and the patient gave permission by signing the back of the envelope. This envelope back was torn off by the pharmacist and stapled to the face of the prescription. If either the physician or the patient indicated 'no generic' the brand drug was to be sent. However, as previously mentioned, all types of errors occurred and improper filling of generic rather than brand name drugs was among the mistakes.

In addition to these pages of testimony I am submitting fourteen pages of photocopied material from my own files which I have found helpful in my own look at mail-service pharmacy operations.

The first article, "Mail Order Prescriptions: The Controversy Continues" by Dr. Eddie L. Boyd is a history of mail order pharmacy complete with 14 references for further reading.

The second article, "Mail-Order: A Disaster Waiteth" by Jim Dickinson should be interesting reading for the committee as it is a prediction of what is now occurring in mail order pharmacy.

I included a third article, a copy of the State Board of Pharmacy newsletter of May, 1984 because it details the Attorney General's opinion about pharmacists filling out-of-state prescriptions. It does not address the sending of prescriptions out of state. However, before joining the staff of National Rx Services, a colleague and I phoned the State Board of Pharmacy and were assured that our practice at National would meet with their approval.

The fourth article, actually a Drug Store News Continuing Education Program lesson from 1980, "Drug-Related Problems and The Geriatric Patient" came to mind because a good percentage of the patients serviced by National Rx are retired senior citizens. On page 3, under the headings, 'Patient Errors and Compliance' and 'Patient Education' it points out that studies have shown verbal reinforcement by a pharmacist helps ensure proper drug usage. This is not possible via mail order prescription service.

The last exhibit is included to bring to the committee's attention the over-size National Rx want ads that have appeared two to three times a week in our city's major newspaper. It is interesting to note that on 19 July, 1987 the "additional earnings potential based on bonus system" of 15 July, 1987 and earlier was replaced by "time and a ½ for overtime" although as of this date the bonus system is still in effect.

It is also interesting to note that these obvious calls-for-help, we-need-pharmacists announcements have not even been able to replace the seven pharmacists who have left the facility since May of this year. Although the financial rewards are greater than in any other pharmacy in town and a large pharmacy graduating class from the local university is out seeking employment, National Rx is having problems in recruiting. What's wrong? I trust that each member of the committee will be able to answer that question on his own at the termination of these hearings. Thank you.

Mail Order Prescriptions:

The Controversy Continues

by Eddie L. Boyd, Pharm.D.

Use of the mail to deliver consumer goods to people in rural areas originated many years ago, and the recent 50 percent increase in the use of mail order catalog companies to purchase goods has not excluded pharmaceutical services.[1]

Since mail order pharmacies can allegedly decrease the cost of prescription drugs up to 50 percent, and sponsors of third-party health care programs are seeking ways to cut the cost of services they provide, several companies are offering mail order prescription options to their workers.

The nation's largest mail order prescription service is operated by the Veterans Administration, which filled 19.3 million prescriptions in the 1983 fiscal year. The next two largest providers of mail order prescription services are the American Association of Retired Persons Pharmacy Service (AARP) filling approximately 5 million prescriptions per year, and National Pharmacies filling approximately 2 million prescriptions per year.[2]

The Veterans Administration's program was initiated in 1946 and is a free service provided to veterans who meet the eligibility requirements. The for-profit public mail order programs started in the 1950's and AARP's program began in 1959.[3] It was not until the 1980's that the advent of mail order prescription programs as an optional benefit to union workers occurred.

Examples of organizations which have recently begun to offer mail order prescription plans include Comp-U-Card (Stamford, Conn.), an electronic shop-at-home service with approximately one million subscribers, whose members can charge prescriptions via VISA cards issued by Bank One, Columbus, Ohio.[2]

Ford Motor Company, through Health Care Service of Chester, PA, offers mail order service on maintenance drugs to its hourly and salaried employees.[2] Pennsylvania Employees Health and Welfare Fund offers a mail order prescription option through its administrator, the American Federation of State, County, and Municipal Employees (AFSCME).

General Motors, Uniroyal, and what appears to be an increasing number of companies also offer mail order prescription options to their workers and retirees.[4,5] The incentives which are being used to encourage employees to use the mail order plans are decreased co-pay for mail order vs. regular pharmacy services and claims that use of mail order plans will provide an overall savings to the companies. To date, there has been no published information demonstrating that mail order prescription plans provide overall savings to the companies that are encouraging their workers to use them.

An Early Study

One of the earliest and most complete observations of the mail order prescription drug industry was conducted in the 1970's by Wertheimer and Knoben.[3] Collecting information from professional organizations and state boards of pharmacy, they generated a list of approximately 60 firms engaged in high volume mail order distribution of prescription drugs. Using this data base, the general features of mail order pharmacies, e.g., patient characteristics, services offered, prescription pricing practices, prescription processing methods, prescription shipping and prescription volume were outlined.[3]

The authors also discussed general mail order prescription services and described special features or characteristics of some of the firms they studied. They concluded by recommending that organized pharmacy conduct an objective evaluation of mail order drug distribution and help establish standards for the industry.

Unfortunately, the recommendation by Wertheimer and Knoben was not followed and the controversy regarding mail order prescription services has continued to this date. In fact, over the years, the reaction of pharmacists and organized pharmacy to mail order prescription plans has been less than positive and frequently confrontational. The reactions have included everything from accusing the pharmacists who work in mail order pharmacies of being unethical to suing the mail order pharmacies in attempts to close them down.

A Brief History

In 1972, Kenneth Griswald, Chairman of the Judicial Board of the American Pharmaceutical Association (APhA), expressed the opinion that pharmacists practicing in mail order pharmacies must be presumed to be engaged in unprofessional conduct in violation of Sections One, Four, Seven, and Eight of the APhA Code of Ethics.[6]

In the early 1970's, mail order pharmacies were accused of unknowingly filling forged prescriptions because of the inability to know the prescribing practices of local physicians. The Associate General Counsel for the National Association of Retail Druggists (NARD) wrote Senator Birch Bayh on August 7, 1972, and stated, "We are confident that any responsible investigation of mail order practices by Congress, Bureau of Narcotics and Dangerous Drugs (BNDD, now DEA), or any other group will demonstrate that widespread use of the mail to deliver drugs subject to abuse contributes to drug diversion and the nation's drug abuse problem. . .An outright prohibition on the mail order sale and delivery of drugs subject to abuse is essential and long overdue."[3]

Printed with permission from the Michigan Pharmacist, Volume 24, No. 1, January 1986.

Two months later, John Ingersoll, director of BNDD stated that in 1969 the Bureau had conducted an investigation of mail order pharmacies and concluded, at that time, that they were not a major source of diversion of controlled drugs. He went on to say that the level of compliance for mail order pharmacies with the Drug Abuse Control Amendments of 1965 compared reasonably well with the general run of prescription pharmacies.[3]

In 1972, members of an Arkansas grand jury had prescription blanks printed and wrote prescriptions for controlled substances, then sent the prescriptions to mail order pharmacies in Missouri, the District of Columbia, and Iowa. After the prescriptions were filled at the pharmacies, the grand jury attempted to have the pharmacists who filled the prescriptions extradited to Arkansas for prosecution. The extradition attempts were not successful.

In 1977, Federal Prescription Services, Inc. filed suit against APhA, some state pharmaceutical associations, the National Association of Boards of Pharmacy, the American College of Apothecaries and the Iowa Board of Pharmacy for alleged violation of the antitrust laws by their lobbying efforts against mail order pharmacies.

On February 14, 1980, Judge Gerhard A. Gesell, in the U.S. District Court for the District of Columbia, ruled that APhA was guilty of antitrust violations and awarded Federal $102,000 plus attorney fees and costs. On August 12, 1981, the U.S. Court of Appeals for the District of Columbia overturned Judge Gesell's decision, and ruled that APhA was not guilty of antitrust violations.[7]

State laws normally require pharmacists and pharmacies to be licensed in the states where they dispense prescriptions. Some states, including Arkansas,[8] Wisconsin,[9] and California,[10] have obtained Attorney General opinions that mail order pharmacies mailing prescriptions to those states must be licensed by said states.

Since in many states it is illegal for a pharmacy to mail a prescription that was received via mail, technically, mail order pharmacies that mail prescriptions to those states are in violation of the pharmacy laws. However, the most severe sanction a Board of Pharmacy can take against a pharmacy that violates the law is to remove that pharmacy's license, and this type of action, if possible, probably would not solve any problems or prevent mail order pharmacies from operating.

To date, there has been no published information demonstrating that mail order prescription plans provide overall savings to the companies that are encouraging their workers to use them.

(Continued)

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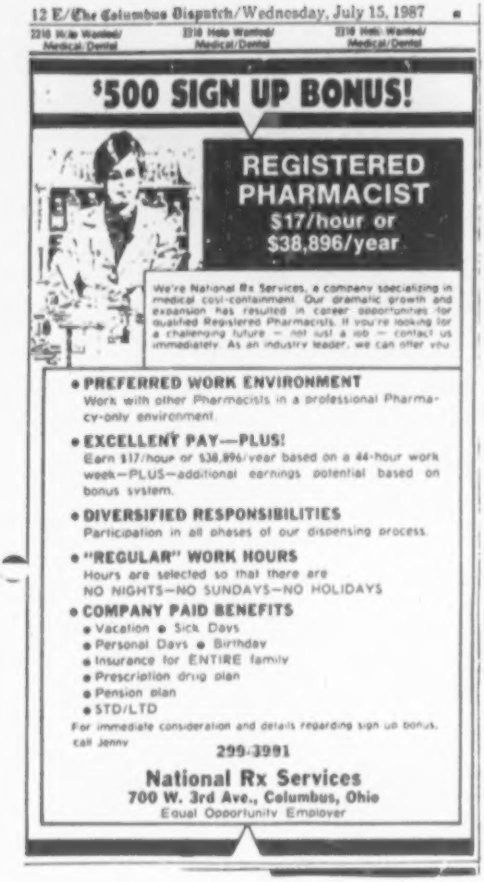

12 E/The Columbus Dispatch/Wednesday, July 15, 1987

2210 Help Wanted/ Medical/Dental | 2210 Help Wanted/ Medical/Dental | 2210 Help Wanted/ Medical/Dental

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$17/hour or
$38,896/year

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  Hours are selected so that there are
  NO NIGHTS—NO SUNDAYS—NO HOLIDAYS
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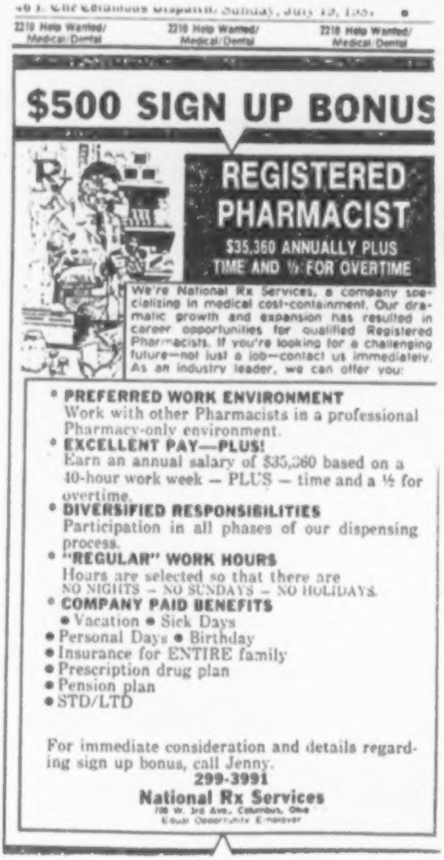

40 E/The Columbus Dispatch/Sunday, July 19, 1987

2210 Help Wanted/ Medical/Dental | 2210 Help Wanted/ Medical/Dental | 2210 Help Wanted/ Medical/Dental

$500 SIGN UP BONUS

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$35,360 ANNUALLY PLUS
TIME AND ½ FOR OVERTIME

We're National Rx Services, a company specializing in medical cost-containment. Our dramatic growth and expansion has resulted in career opportunities for qualified Registered Pharmacists. If you're looking for a challenging future—not just a job—contact us immediately. As an industry leader, we can offer you:

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The Controversy Continues

From the foregoing discussion, it is apparent that the controversy regarding mail order prescription services continues to rage. However, there has been no systematic study of mail order pharmacies to determine whether their services are inferior or superior to those provided by traditional pharmacies.

Cost Savings. One of the purported benefits of mail order prescription plans is that the companies can allegedly save patients 30 to 50 percent on their drug costs. In advertising these types of savings, the companies mislead consumers because they are normally comparing apples to oranges, e.g., comparing the costs of generic products dispensed by mail order pharmacies to the costs of brand-name products dispensed by traditional pharmacies.

The major cost savings mail order companies can provide are those derived from volume purchasing, dispensing large quantities of medications, and the use of generics. When one compares the cost of brand-name products (those still on patent) with mail order pharmacies, independent pharmacies and chain pharmacies, the prices are not significantly different. When talking to representatives from mail order pharmacies, they are very eager to quote prices for generic drugs, but more reluctant to quote prices for drugs still on patent for which there are no generic equivalents available.

Other Services. Some of the services provided by mail order pharmacies are beneficial to patients. For example, the provision of braille labels on prescriptions by mail order pharmacies could be a valuable service if a significant number of patients with decreased vision could read braille.[12]

Also, the provision of written drug information with prescriptions mailed by mail order pharmacies also have toll-free telephone numbers to be used for questions about the drugs they dispense. However, it is much more difficult for patients serviced by mail order pharmacies to obtain emergency prescriptions and personal consultation by a pharmacist. Lack of a complete profile of all drugs, including nonprescription drugs, being taken by a patient is more of a problem with mail order pharmacies than with other types of pharmacies. Delays in obtaining prescriptions also occur more frequently when patients use mail order pharmacies than when they use traditional pharmacy services.

PROBLEMS Center Established

When General Motors and Ford Motor Company, in agreement with the United Auto Workers, offered their employees the option of participating in a mail order prescription plan, the Michigan Pharmacists Association (MPA) established a PROBLEMS Center to gather information from patients who have experienced problems with the mail order prescription service.[13] The establishment of the Center was advertised in several pharmacy journals, and pharmacists were advised to call the Center whenever problems with mail order prescription services occurred in their area and/or practice. The Center's activities were handled by regular MPA staff, and funds were not available to advertise the availability of the Center to consumers.

The unions were reluctant to support the Center, and there appears to be no mechanism for union members to systematically report problems with the mail order plans to the unions. As of December 1985, problems reported to the Center by pharmacists or other health care practitioners were considered "reported" problems and those reported by the patient or a family member were considered "documented" problems.

Some of the documented problems caused by the utilization of mail order prescription services include the following:

- A package of medication was left in a not frequently used doorway of a home without the required signature needed for delivery. The patient felt that the package of medication had been tampered with and had difficulties obtaining replacements from the mail order company.
- A retiree did not want generic drugs but felt she had no choice since the company from which she retired is "forcing her to use mail order."
- Reported delays in receiving filled prescriptions varied from one to five weeks, and the medications included Tylox®, Empirin #4®, Nitrobid®, Coumadin®, insulin, furosemide, Slow K®, Lanoxin®, allopurinol, and Depakote®.
- There were some reports of medication errors including wrong quantities and strengths being received and ordered prescriptions not being delivered.
- One patient mailed a prescription for Valium® to be filled and received Nolvadex® (an anticancer drug) from the mail order pharmacy.
- One pharmacist had to open his store on a Saturday afternoon to dispense an emergency supply of antihypertensive medications to a former patient who had switched to a mail order pharmacy and did not receive her medication refills before her supply ran out.
- There had been one documented situation that involved a patient who was abusing a drug and the pharmacists working with the physician, family members and insurance company had established a system to control the amount of the drug the patient could obtain. The patient forged a prescription for the drug and mailed it to a mail order pharmacy and obtained additional quantities of the drug. This resulted in re-addiction to the drug received through the mail order plan.
- Because of delays in receiving mail order prescriptions, there was one reported case of a patient receiving 440 Percodan® tablets using local and mail order pharmacies in an attempt to insure that he does not run out of medication.

Delays in Delivery. The problem most frequently associated with mail order prescription services appears to be delays in the delivery of medications, leaving the patient without adequate supplies of maintenance drugs. Some patients attempt to avoid this problem by ordering their refills early. However, some of the mail order pharmacies have a policy that they do not refill prescriptions more than 15 days before the previous supply of the drug should be exhausted.

Liability

An interesting question that has been recently raised regarding mail order prescription services concerns the issue of liability or shared liability by the unions and companies who promote and/or offer the plans. The specific question that has been raised is, "If the mail order plan is mandatory or promoted by the union and/or company and the patient suffers an injury because of use of the plan, e.g., delayed medication, etc., is the company and/or union liable?"

Summary

Mail order prescription plans have been promoted to union members as a way to help keep the cost of health care down. Ford Motor Company and Uniroyal have had their plans for two years and General Motors has had its plan for one year.

In considering the potential problems that obtaining medications by mail can cause for patients, the Michigan Pharmacists Association has called upon the companies and unions who promote these plans to their workers and members to present data demonstrating that their mail order prescription plans save money, what the savings are, and to what they can be attributed, e.g., use of generics, etc.

Many pharmacists have expressed the opinion that mail order pharmacies cannot possibly provide the same level of service as local pharmacies. However, as indicated earlier, there have been no systematic studies of the services provided by the two types of practice to determine whether or not one type is better than the other.

Perhaps it is time that pharmacists deal with this type of competition at a different level, e.g., making every effort to save patients and third-party providers money by dispensing quality generic drugs when, in their professional judgement, this is appropriate, and by explaining to consumers and third-party providers that the only cost savings mail order pharmacies can provide are those related to volume purchasing and dispensing large quantities of medication, and by making every effort to provide patients with written and verbal information with each prescription and nonprescription drug dispensed or sold.

Mail order pharmacy services accentuate the need for all pharmacists to provide their patients with personalized convenient professional pharmacy services.[14]

About the Author

Eddie L. Boyd, Pharm.D., is Associate Professor at the University of Michigan College of Pharmacy, Ann Arbor, Michigan.

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Report of the Public Relations Committee
1985 OSPA Annual Meeting

by James Ingram, R.Ph.
Chairman

For the past eight months, the Public Relations Committee has worked at developing a long range public relations campaign. Our goal is to carry pharmacy's message to the public via newspaper advertisements and public service spot announcements on radio and television. We would also like to direct our campaign to labor unions and businesses in Ohio.

Do You Know Who Your Pharmacist Is? We developed the advertising slick on the following page to be sent to newspapers. It is available to local associations who may obtain it by contacting the office. Locals may have their name typeset at the bottom of the ad. If it is used, please send a copy of the publication to the office. If this ad is successful, we may be able to produce more. Our thanks to Staff Vice President Kelly Weasner for her help in its preparation.

Local Support. The committee feels that our public relations program will only be effective if there is support from the local pharmacy associations. We encourage the local associations to form public relations committees. Thus we can form a network around the state for exchanging information and ideas.

Pharmacy Week. We are working with Governor Celeste to proclaim state "Pharmacy Week" for the week of our 1986 annual meeting.

Thanks to our Committee. In conclusion, I would like to thank the many committee members who gave so generously of their time and talent. They are excellent examples of the fine people and good minds in our association. Give us your support and many good things will happen in the coming years.

Committee Members: Mathew Mattmuller, David Marlowe, Thomas Gossel, Louis Marcy, Julie Cosiano, Robert Parsons, Charles Mires.

Dickinson's Pharmacy

Dickinson

by Jim Dickinson

Mail-Order: A Disaster Waiteth

"It's big business, and getting bigger," my lunch companion from industry said. "They're doing over $20 million a year."

Nothing could stop it, he said. We were talking about mail-order prescriptions, and the way some of the big drug chains are getting into it. To help everything along, mail-order prescriptions are being offered as an attractive option to cost-beseiged employers by third-party programs such as PAID Prescriptions, recently acquired by Porex Technologies Corporation, owner of the vast Medco (National Pharmacies) mail-order house.

In addition, the 17 million-member American Association of Retired Persons/National Retired Teachers Association mail order presciption drug operation in Washington, D.C. has long been the biggest single prescription processing center in the country.

The over-65's age group is the fastest-growing age group in the country, and by the year 2025, more people will be middle-aged to elderly than will be young.

All of which adds up to a cosmic chain-reaction atomic boom in mail order prescriptions, right? You betcha — I'm buying all the stock I can get my hands on.

And why not — poor old Grandma, who can't afford $100-per-pill biotech miracle arthritis cure-alls that we're now inventing because zero-deficit Gramm-Rudman federal spending levels won't raise her Social Security or extend Medicare to ambulatory prescriptions, has to get her low-cost medications without walking to the drug store — which means the mail-order option. Right?

Even if she could suffer the pain in her joints enough to stagger out to the HMO or chain drug store two bus sections away from her high rise, she'd probably get mugged by unemployables on the way — which is further grist to mail-order prescription mill. Right?

Lots of people who think they're close to where it's at see this as a clearcut scenario for our future, just a few years from now. That's really the bottom line as to why legislative action against mail-order prescriptions is so hard to get started. In addition, there are other obvious reasons — for profit independent pharmacists charge more per prescription than mail order houses do, and everything they say on this subject is biassed in their own economic interest, so it can be disregarded.

Also, we don't have a body-count we can lay on the mail-order houses' doorsteps.

Not yet, we don't. But as a society, we're working on it. It'll soon be here.

Nobody wants to see it, and those anti-mail-order protagonists out there would all wish that they could win their point without a body-count, but the political/public opinion battlefield will demand solid proof before it sanctions this particular form of restraint-of-trade.

So look for bodies. They'll come in the following ways:

1. As mail order programs begin competing with each other, the mail order option will get into the color supplements of the Sunday papers. Ours is better, faster than theirs — our patient profiles protect you against interactions whereas they don't have any. After a while, traffickers and junkies will figure out that the mailboxes in the old-folks' apartments across the way have drugs in them.

2. Mail carriers will get robbed, drawing more publicity to this problem. Controversy will start on whether "certain" mailmen on particularly hazardous routes should carry guns, go in pairs, or be accompanied by attack dogs.

3. The wrong people will accidentally get mail-delivered prescriptions — e.g., a visiting grandchild, mental incompetents, etc. — and there will be more reported deaths from this cause than at present (there are some, now).

4. Drugs will get contaminated by Postal Service mechanized handling and occasional mishaps — broken containers, loosened closures, become subject to unusual temperature/moisture/smoke/volatile gases in environments sometimes encountered by the mails.

But until any of these things actually happen, and there is an actual body-count to bring before Congress and/or the state legislatures, all this is simply defamatory theory, uttered only for selfish reasons by those who stand to gain economically if mail-order prescriptions and all their many public benefits are in any way restricted. Understand?

This feature is presented on a grant from Mylan Pharmaceuticals, in the interest of promoting the open discussion of professional issues in pharmacy. Mylan Pharmaceuticals accepts no responsibility for the views expressed herein as they are those of the author and not necessarily those of Mylan Pharmaceuticals.

MAY, 1984

Ohio State Board of Pharmacy

65 South Front St., Room 504, Columbus, OH 43215 Published to promote voluntary compliance of pharmacy and drug law.

A quick review of past issues of this State Board Newsletter indicates that the only thing that remains constant is change. Previous issues have discussed changes which have occurred through legislation enacted by the Ohio General Assembly. This issue begins a discussion of changes which have occurred as the result of laws which were enacted or amended by the Legislature in 1971 and 1975, and have recently been interpretated differently due to decisions rendered by the courts (federal and state) and the Attorney General of Ohio.

STATUS OF OUT-OF-STATE PRESCRIPTIONS (1971-1978)

One of the difficult problems facing the practicing pharmacist is patient who presents a prescription written by a practitioner who is licensed and practices in another state. The prescription, in most cases, has been issued by a practitioner in the course of his/her practice for a legitimate medical purpose. The question of whether or not the prescription may be legally dispensed by an Ohio pharmacist has been an issue since the following definition of a practitioner was adopted by the Legislature in 1971:

"Practitioner" means a person licensed pursuant to Chapter 4731., 4715., or 4741. of the Revised Code and authorized by law to write prescriptions for drugs or dangerous drugs.

This definition began to pose serious problems for pharmacists practicing in areas bordering on other states with the adoption of a Drug Abuse Control Act by the Ohio Legislature in 1975. This Act placed those provisions of the Ohio drug laws, which were considered to be primarily criminal in nature, into a separate chapter of the Ohio Revised Code, entitled "Drug Offenses".

The drug offenses are: corrupting another with drugs, trafficking, drug abuse, possessing drug abuse instruments, and the illegal dispensing of drug samples, and are important to practicing pharmacists in that they may be charged with committing these crimes if they have violated any of the provisions of the Pharmacy Practice Act, Dangerous Drug Distribution Act, and the Controlled Substance Act when compounding and dispensing drugs. Both the Federal and o Controlled Substance Acts also provide that a controlled substance prescription is not legal unless it has been issued by a practitioner licensed and authorized by law to prescribe the drug and that such drug is prescribed in the course of their professional practice.

Consequently, an interpretation of the definition of a practitioner that was limited to those persons who hold a current and active license under Ohio's Medical Practice Act (Chapter 4731.), Dental Practice Act (Chapter 4715.), and Veterinary Medical Practice Act (Chapter 4741.) subjected Ohio pharmacists who lived in areas bordering other states to felony charges if they dispensed controlled substance prescriptions written or issued by practitioners in states other than Ohio. This interpretation of the definition of a practitioner was held by the Board until December 20, 1978 when Ohio's Attorney General issued an official opinion that a section of Ohio's Medical Practice Act (Section 4731.36) permitted Ohio pharmacists to legally dispense prescription drugs pursuant to a prescription issued by a person who resides on the border of a neighboring state and was licensed to practice medicine and prescribe such drugs in that state or when such person was in consultation with a person licensed to practice and prescribe drugs in Ohio. This provision of the Ohio Medical Practice Act, however, does not apply to persons licensed under Ohio's Dental Practice Act, the Veterinary Medical Practice Act, to medical practitioners in states other than those bordering on Ohio, nor to medical practitioners who do not reside "on the border" of a neighboring state. Consequently, prescriptions issued by dentists or veterinarians who reside on the border of a neighboring state were not licensed by the Ohio Dental Board or Ohio Veterinary Medical Board, were not legal prescriptions and could not be legally dispensed by Ohio pharmacists. A prescription obtained by an Ohio resident who has been under a practitioner's care at a nationally-recognized medical center in a state other than one bordering on Ohio also could not be legally dispensed by an Ohio pharmacist unless the prescriber was also currently licensed by the Ohio Medical Board.

Another problem with this section of the Medical Practice Act was the limitations of the phrases, "*residing* on the border of a neighboring state" and "whose practice extends within the limits of this state". The Ohio law does not indicate what is considered to be the extent of the border of the neighboring state. For example, a medical practitioner who residence is in Lexington, Kentucky might be considered to be outside the provisions of Ohio's Medical Practice Act and his/her prescriptions could not be legally dispensed by Ohio pharmacists in Cincinnati.

STATUS OF OUT-OF-STATE PRESCRIPTIONS (1982 to present)

In 1982, the Ohio Board of Pharmacy began receiving inquiries as to whether or not the interpretation of Ohio's definition of a practitioner was correct and whether or not an Ohio pharmacist could dispense drugs pursuant to a prescription written for legitimate medical purposes by any practitioner licensed and authorized to prescribe drugs in another state without limitations. These questions came from pharmacists who were receiving prescriptions from dentists, veterinarians, optometrists, and medical practitioners who did not reside on Ohio's borders. Questions also came from legislators

Contd. on page 4

who were receiving complaints from Ohio pharmacists concerning the fact that pharmacies located in other states could fill prescriptions written by Ohio practitioners but that Ohio pharmacists could legally fill only those prescriptions written by practitioners licensed to practice in Ohio or out-of-state medical practitioners who fell within the narrow provisions of the Ohio Medical Practice Act's exemptions.

These inquiries resulted in the Board of Pharmacy requesting an official opinion of the Attorney General regarding prescriptions issued by persons who are licensed and authorized to prescribe drugs in the es whre they are practicing. The official opinion was issued by the Attorney General in June, 1982 and is as follows:

"An Ohio pharmacist may dispense drugs pursuant to a prescription issued by a non-resident practitioner who is licensed and otherwise atuhorized to issue prescriptions for drugs in a state other than Ohio, and, if the prescription is for controlled substances, who is registered under the Federal Controlled Substance Act, even though the non-resident practitioner is a person, such as a midwife or physician assistant, who would not be permitted to issue prescriptions if practicing in Ohio."

This Attorney General's decision provides a legal basis for Ohio pharmacists to dispense any prescription which has:

(1) been issued by a person licensed in another state and authorized to prescribe the drug in that state, and if the prescription is for a controlled substance, the prescriber is registered with the Federal Drug Enforcement Administration; and,

(2) been issued for a legitimate medical purpose by a practitioner acting in the usual course of his/her professional practice in the state where the prescription was issued.

DISCIPLINARY ACTIONS

Anyone having a question regarding the license status of a par- 'ar practitioner, nurse, pharmacist, pharmacy intern, or dangerous drug distributor in Ohio should contact the licensing board which regulates that profession or activity, as follows: State Dental Board (614/466-2580); State Medical Board (614/466-3934); State Nursing Board (614/466-3947); State Pharmacy Board (614/466-4143).

STATE MEDICAL BOARD:

Samuel W. Madison, D.P.M., D.M.; Columbus, Ohio–Licenses (podiatry and mechanotherapy) indefinitely suspended–12/01/83.

STATE PHARMACY BOARD:

Drug Law Violations

Alice M. Allen, R.Ph.; Toledo, Ohio–License revoked–12/02/83. Board's Order under appeal, stay granted by court. Court lifted stay on State's motion for reconsideration, 02/29/84. **Robert D. Bushey, R.Ph.**; Sandusky, Ohio–License suspended 24 months; stayed 18 months, must take and past jurisprudence exam; $1,000 monetary penalty–03/23/84. **Gerald J. Cooper, R.Ph.**; Toledo, Ohio–License suspended 2 years; $3,000 monetary penalty–01/12/84. **Floyd A. Steward, R.Ph.**; Toledo, Ohio–$5,000 monetary penalty–01/12/84. **Joseph A. Carano, D.O., Inc., Terminal Distributor**; Warren, Ohio–License revoked–10/24/83. Board's Order under appeal, stay requested and denied. Appeal withdrawn, 03/23/84. **Detroit Family Practice, Inc., Terminal Distributor**; Cleveland, Ohio–License renewal application denied–03/23/84. **The Kroger Company, Terminal Distributor**; 1014 Vine Street; Cincinnati, Ohio–$3,000 monetary penalty–01/12/84. **Sam's Orchard Drugs, Inc., Terminal Distributor**; Toledo, Ohio–$2,000 monetary penalty–01/12/84. **Umbles Drew-Hale Pharmacy, Inc., Terminal Distributor**; Toledo, Ohio–License revoked; $4,000 monetary penalty–12/02/83. Board's Order under appeal, stay granted by court. Court lifted stay on State's motion for reconsideration, 02/29/84. Pharmacy closed, 03/16/84.

Ceased to Qualify for Licensure

Kilonsky Clinic, Inc., Terminal Distributor; Tallmadge, Ohio–License revoked–01/12/84.

Late Renewal of Pharmacist Identification Card

Loetta Bates, R.Ph.; Worthington, Ohio–$100 monetary penalty –03/23/84. **Paul Benjamin, R.Ph.**; Beachwood, Ohio–$100 monetary penalty–03/23/84. **Alton W. Curry, Jr., R.Ph.**; Poland, Ohio–$100 monetary penalty–03/23/84. **James H. Geyer, R.Ph.**; Oxford, Ohio –$100 monetary penalty–03/23/84. **Barbara J. Harmon, R.Ph.**; Miamisburg, Ohio–$100 monetary penalty–03/23/84. **Stephen D. Harris, R.Ph.**; Ashville, Ohio–$100 monetary penalty–03/23/84. **James H. Parks, Jr., R.Ph.**; Toledo, Ohio–$500 monetary penalty–01/12/84. **David B. Shaw, R.Ph.**; Lebanon, Ohio–$100 monetary penalty–03/23/84. **Walter H. Weyrauch, R.Ph.**; Tipp City, Ohio–$100 monetary penalty–03/23/84. **Earle J. Yarley, R.Ph.**; Englewood, Ohio–$100 monetary penalty–03/23/84.

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Franklin Z. Wickham, R.Ph.–State News Editor
David E. Holmstrom, J.D., R.Ph.–National News Editor
D.J. Lambert–Managing Editor
Diane Griffin–Production Assistant

National Association of Boards of Pharmacy Foundation, Inc.
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DRUG STORE NEWS CONTINUING EDUCATION PROGRAM

DRUG-RELATED PROBLEMS AND THE GERIATRIC PATIENT

James W. Cooper Jr. Associate Professor and Head, Department of Pharmacy Practice School of Pharmacy, Athens, Georgia

GOALS
To review the most common drug-related problems of the geriatric patient, discuss some of the factors related to these problems and present methods and special drug considerations to enable the pharmacist to anticipate and prevent these problems.

OBJECTIVES
The pharmacist should be able to:
1. Identify the geriatric patient at risk of drug-related problems.
2. Differentiate potential to possible drug-related problems that may be occurring from other contributing factors.
3. Recommend solutions to patient and prescriber aimed at reducing these problems.

For enrollment details, contact Pharmaceutical Editor Drug Store News,
99 Park Ave., New York, N.Y. 10016.

Lesson #679-401-80-14 Oct. 27, 1980

DRUG STORE NEWS

CONTINUING EDUCATION PROGRAM

Drug-Related Problems And The Geriatric Patient

The purpose of this paper is to introduce the pharmacist to perspectives and skills that promote appropriate drug use in the elderly patient. A discussion of pertinent data regarding rationality of drug therapy, most common drug-related problems of misuse, and adverse reactions and physiologic, pharmaceutic and pharmacologic factors contributing to these problems is presented. Methods for reduction of these problems including complete drug history, patient education and dosing by lean body weight and renal/hepatic function with due attention to special consideration for particular drugs are also given.

The elder, however, should be approached as a unique individual. Each drug prescribed or recommended should have a readily definable endpoint of effect (beneficial/toxic) that should be reached within a specified period of time. Due attention to this concept as well as the *total* patient profile every time a new drug is added can reduce unnecessary therapy. An example would be, keeping in mind, the fact that diphenhydramine (Benadryl®) is not only an antihistamine, but also has antiemetic, anticholinergic, antitussive and sedative properties that make it useful on an intermittent basis for a number of symptomatic complaints of the elderly. Due attention must be paid to symptomatic complaints and one must always look at patient profile of RX and OtC drugs and ask (Would removing a drug benefit the patient more than adding a drug?) or, (Could this problem/complaint be caused by a drug[s] the patient is taking?).

Some emminent geriatricians feel that oldsters are best managed with five or fewer chronic use drugs, so always encourage trying to taper the patient to this "magic number" for several reasons: 1) cost 2) rational and 3) incidence of adverse reactions increase in *geometric* (not arithmetic) fashion as the number of medications per patient increases.

GERIPHARMACOTHERAPY

Several studies have found that elderly patients had a higher frequency of drug-related admissions to hospitals than younger patients. Up to one-third of elderly patients admitted to two small community hospitals had drug-related problems (DRP's) that contributed to their admission. Fully two-thirds of DRP's were misuse and the other third were adverse reactions and interactions. In hospitalized patients over 60 to 70 years of age the risk of drug reaction is almost 1½ times that in adults 30 to 40 years of age. On the other hand 70%-80% of drug reactions are supposedly preventable.

In 1972, Americans 65 and over received 22% of all Rx drugs even though they comprised only 9% of the population. By 2025 they will compose over 20% of the population. While we tend to think of the older person (65 or older) as being seminvalid to institutionalized, it's essential to remember that only 5% are institutionalized while 95% are found in their home in the community. And since the patient has more access to the community pharmacist than any

Table I
MOST COMMONLY PRESCRIBED DRUGS

Drug Name *	Noninstitutionalized Rank	Institutionalized Rank
Analgesic with Codeine	1	9
Methyldopa (Aldomet)	2	NR **
Furosemide (Lasix)	3	3
Indomethacin (Indocin)	4	6
Hydrochlorothiazide with triamterene (Dyazide)	5	15
Hydrochlorothiazide	6	13
Potassium chloride	7	5
Chlorpropamide (Diabenese)	8	NR
Thioridazine (Mellaril)	9	1
Digoxin (Lanoxin)	10	4
Al/Mg Hydroxide (Maalox)	11	12
Hydrochlorothiazide with Spironolactone (Aldactazide)	12	NR
Meclizine	13	NR
Papaverine	14	11
Tetracycline	15	NR
(Hydergine)	NR	2
Choral hydrate	NR	6
Chlorpromazine (Thorazine)	NR	7
Haloperidol (Haldol)	NR	8
Amitriptyline (Elavil)	NR	10
Al/Mg Hydroxide with Simethicone (Mylanta)	NR	14

*Generic Name (trade name)
**NR = not ranked

Indiana and Texas have not passed drug product selection.

other health care practitioner, we have the greatest potential of preventing drug-related problems. The most frequently prescribed drug classes in a recent California Medicaid study of institutionalized and noninstitutionalized patients is given in Table 1.

While the elderly patient in a nursing home may receive simultaneously an average of from five to seven drugs almost one-fourth of drugs prescribed have been found in one nursing home study to be unnecessary and/or not effective and up to one-fourth of the patients were placed at risk of potential drug interaction by multiple drug usage in another study. As the number of drugs prescribed for an individual increases so does the rate of adverse reactions and noncompliance.

Multiple drug therapy may often be unavoidable in documented cardiovascular-hypertensive, endocrine, infectious diseases and psychiatric problems. These conditions do represent a definite threat to well-being and/or life and may be more difficult to treat in the elderly patient.

In all 84%-87% of elderly ambulatory and 95% of institutionalized elderly patients are reported to be taking prescription drugs and in 100 consecutive nursing home admissions 64% of the patients' primary diagnoses were inaccurate; 84% of the secondary diagnoses were either lacking or inadequate. Most inaccuracies concerned psychiatric problems. The inadequate performance in identifying clinical and therapeutic problems of the chronically ill aged was remarkably consistent, regardless of whether patient referral was from a general or psychiatric hospital, the patient's home or another nursing home. If the preadmission diagnosis is incorrect in so many patients admitted to long-term care facilities, how can the preadmission drug therapy be rational?

Another group found the *least* mentally impaired and *most physically active* nursing home patients were the most heavily "drugged" with neuroactive substances. A recent physician survey demonstrated generalized physician lack of interest in the care of ill aged patients in institutions.

PATIENT ERRORS AND COMPLIANCE

Patient errors of comission and/or omission in the self-administration of drugs in ambulatory elderly patients are common. One report found that 59% of an elderly outpatient population with chronic illnesses made errors in the self-administration of prescribed medications and more than 25% committed potentially serious errors. Omission was the most common error. In another study of ambulatory patients who self-administered drugs in a skilled nursing facility and/or a hospital, a 60% error rate was seen in those who received drugs without instructions, whereas only a 2.3% error rate was seen in instructed patients.

The need for supervision of the elderly patient receiving long-term drug therapy was recently re-emphasized in a study in which 20% of randomly selected elderly patients taking medications had no recorded contact with their physician for six months or longer. Another survey of elderly patients (conducted in their homes) found that many stored their drugs improperly, tended to hoard drugs and did not have enough explicit instructions regarding indications for taking the drugs. In the study of drug-related problems influencing the need for admission, lack of patient knowledge of their drugs (What is the name of your drug, how do you take it, what do you expect from it?) was found in 48%.

PATIENT EDUCATION

In the elderly patient who has a number of needed medications, impaired memory or thought processes, the pharmacist should be willing to help ensure proper drug usage by continuously reinforcing instructions verbally and with drug profile and memory aids. It is essential that the pharmacist ensure this process in both the pharmacy and the patient's home environment. Home health care programs are beginning to realize the need for and cost justification of the pharmacist in reviewing the patient regimen and ensuring that home health personnel identify all drugs and make sure that the patient can use all drugs in a responsible manner. The pharmacy with delivery service can tremendously aid the patient by not only getting the drug to the patient but by providing health and drug education/information.

Discussion of pertinent instructions with the patient is essential in order to ensure success of such patient education. The simple question (What do you know about the use of this medication?) often helps reinforce this information. The following 16 points should be *comprehended* by the geriatric patient. See next page.

DRUG HISTORY

Guidelines for taking and maintaining good drug histories include a drug list/profile, good history technique and persistent re-evaluation. On first and subsequent revisits the drug history profile must be gained and updated especially if the patient is seeing multiple prescribers.

It is essential to determine compliance between visits. Confirming refill dates is an excellent method for determining both refill patterns and other drugs the patient may have obtained from other prescribers. Dosage forms counts and prodding (We all miss doses from time to time. How many times per week or month do you?) as well as open-ended questions (How have you been taking your medication?) may be necessary to gain an accurate history, especially in chronic disease states where compliance is known to be a problem (hypertension, congestive heart failure, chronic lung disease and peptic ulcer disease).

DOSING, BIOPHARMACEUTIC AND PHARMACOKINETIC FACTORS

In terms of drug dosing, from 25% to 30% of body cells and functional capacities are lost from age 30 to old age at a persistent and irreversible rate of about 1% per year. This suggests that whenever medications are definitely needed in the elderly that their dosage should be tapered by 20% to 50% or more. When this

DRUG STORE NEWS CONTINUING EDUCATION PROGRAM

factor is not taken into account, higher tissue levels and increased incidence of adverse effects are seen especially with digoxin, anticoagulants, phenylbutazone and the aminoglycosides. Dosing of all drugs should be by lean body weight, i.e., 5' = 100 (females) or 110 (males) pounds plus 5 pounds per inch.

Intact tablets have been found in the stools of older patients. This finding may reflect biopharmaceutic problems of poor formulation.

If the drug(s) being utilized are of proven bioavailability and the patient is actually taking the medication as prescribed, the influence of the disease state on drug response must be considered. Diseases which may particularly predispose the elderly patient to inappropriate drug effect are those that primarily affect the absorption, distribution, metabolism and excretion of drugs, e.g., congestive heart failure, hepatic and renal disease.

Reduced or delayed absorption of some vitamins, minerals, and sugars have been found in the elderly but increased absorption has been reported for some essential amino acids. Significant differences in absorption of drugs by the elderly have not been reported in the absence of disease states or conditions leading to malabsorption (congestive heart failure, rheumatoid arthritis, sprue). It is believed that many older patient's therapeutic failures are more related to failure to take the drug rather than failure to absorb the drug.

Since most drugs are carried and distributed by the water containing areas of the body, it is important to realize that both total body water and intracellular water decrease with age. Fur-

ELDERLY PATIENT EDUCATION

- Understand why he/she is taking the medication and why the drug is needed. Patients tend to comply with the physician's instructions more closely if they understand the reason for taking the medication.
- Understand the dosing schedule, so the medications will be taken on time and properly sequenced. Doses should be keyed to activities of daily living (brushing teeth, meals, bedtime).
- Get medication refilled on time; therapy will not be interrupted.
- Know that there may be some side effects caused by drugs and understand the relative importance of these effects. This prevents unnecessary concern over minor side effects and to prevent unwarranted discontinuance of the drug because of these effects.
- Know any special storage requirements for the drug, i.e., refrigeration, etc. This prevents deterioration of the drug. Never store drugs in bathroom medicine cabinet due to high humidity.
- Know any special directions fur using the drug. Can it be taken with food or milk? Will it increase the skin's sensitivity to sunlight? Safe and effective utilization of drugs by the patient is promoted.
- Have the ability to monitor his or her own therapy including the reporting of any untoward or suspicious effects. This guards against drug-induced disease, allergy and to ascertain that the drug is doing what it was intended to do.
- Understand that the prescription is tailored for one person only and should, therefore, not be shared or offered to friends. This prevents abuse and misuse of prescription drugs and possible fatal or serious accidents.
- Know that the pharmacist can give useful advice about nonprescription and prescription medications. This is a readily available but underused resource for the geriatric patient to help in preventing drug interactions and the irrational use of medications.
- Know that all health care practitioners need to know and care about the drug(s).
- Know that easy-to-open closures on prescription bottles are available for the asking. These closures help avoid the frustrations of opening safety caps.
- Be able to develop a medication calendar to aid in proper dosing. This is an important aid-to-memory for patients on multiple medications.
- Have respect for medications. Drugs are effective when used properly but dangerous when misused.
- Prepare and carry a wallet drug profile card.
- Know that many over-the-counter drug products should not be used by the elderly and (or) may interfere with the action of some prescription drugs. Unexpected drug-induced problems are avoided and it assures the proper action of prescribed drugs.
- Have special labels for impaired vision.

TABLE 2
SELECTED DRUGS TO BE USED WITH CAUTION AMONG THE ELDERLY

Amikacin[2]—Amikin
Allopurinol[2,5]—Zyloprim
Amphetamines
Antidepressants
Aspirin[1,3]
Atropine, Scopolamine
Antihypertensives
Barbiturates[3]
Bishydroxycoumarin[4]—Dicumarol
Bromides
Chloramphenicol[3]—Chlormycetin
Chlordiazepoxide[3]—Librium
Clofibrate[1,7]—Atromid—S
Chlorpropamide[3]—Diabinese
Codeine
Colistin[2]—Colymcin
Cortisone-related agents[1]
Diazepam[3]—Valium
Dextrothyroxine[7]—Choloxin
Digotixin[2,3,6]
Digoxin[2,6]—Lanoxin
Epinephrine
Flurazepam[6]—Dalmane
Gentamycin[2,6]—Garamycin
Guanethidine[2]—Ismelin
Haloperidol—Haldol
Heparin[4]
Hydralazine—Apresoline
Indomethacin—Indocin
Isocarboxazid[3]—Marplan
Kanamycin[2,6]—Kantrex
Lidocaine[3]
Lithium Salts[2]
Liothyronine—Cytomel
Methyldopa[2,3] Aldomet
Mineral Oil (prolonged regular use)
Morphine[2]
Nalidixic acid[2]—Negram
Nitrates (long acting) Peritrate, Isordil
Neomycin[2]
Oxyphenylbutazone[1,2]—Tandearil
Pargyline—Eutonyl
Phenothiazines[3]—Thorazine Compazine, Mellaril, Sparine, etc.
Phenytoin[3,5]—Dilantin
Phenylbutazone[1,2,5]—Butazolidin, Azolid
Pipradol—Meratran
Polymyxins[2]
Procainamide[2]—Pronestyl
Propranolol—Inderal
Quinidine[2]
Rauwolfia Alkaloids—Reserpine, etc.
Spironolactone[2]—Aldactone
Sulfonamides[2]—Triplesulfas, Gantrisin, Gantanol
Testosterone
Tetracyclines[2,3]
Tobramycin[2]—Nebcin
Tolbutamide[1]—Orinase
Thiazides—Diuril
Thyroid
Tranylcypromine—Parnate
Trihexylphenidyl—Artane
Triamterene[2]—Dyrenium
Warfarin[1,5]—Coumadin

Number Key

[1] Especially with oral anticoagulants.
[2] If renal function is diminished.
[3] If hepatic function is diminished.
[4] Women over 60 years in particular.
[5] Genetic variation in metabolism exists.
[6] Prolonged half—life in "healthy" elderly.
[7] Increased cardiovascular morbidity and mortality shown in some studies.

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*Caution means dosage and/or dosing intervals may change for the elderly.

thermore, the albumin which is the principal serum protein which binds highly bound drugs such as phenytoin, warfarin and salicylate has been shown to decrease with age and impaired liver function. At the same time, much muscle tissue is being replaced by fat. Drugs distributed in muscle (most drugs) would therefore have less mass for distribution (e.g., digoxin) and those with high lipid solubility would be stored for longer periods (e.g., antipsychotics and glutethimide).

Thus, as a person ages there is less water and muscle tissue in which to distribute the drug and less albumin to bind those drugs significantly bound by plasma protein—the net result is higher total tissue and free drug levels.

Marked differences in the elderly patients' metabolic capability have been shown for phenylbutazone and benzodiazepines (especially Valium® and Dalmane®). This may reflect a decrease in hepatic cells which begins in the absence of prior liver disease at age 50 to 60. While serial liver enzymes, bilirubin and prothrombin times may be useful lab indices in organic liver disease, this functional decline may not be evident from these usual liver function tests. For those with impaired liver function who take drugs that are extensively metabolized by the liver (e.g., digitoxin, tetracyclines, chloramphenicol, macrolides and most CNS depressants) the risk of toxic accumulation is great.

The functional reduction in renal excretory rates seen in the aged may be balanced to a degree by slower absorption and altered transport and cells utilization, but for those drugs primarily excreted by the kidney significant increases in body residence time may occur with resultant toxicity. Table 2 lists those drugs that require dosage and/or dosing interval modifica-

DRUG STORE NEWS

CONTINUING EDUCATION PROGRAM

tions in functional or organic renal and/or hepatic impairment. It is important to realize that the linear decline in functional nephrons that occurs with aging may be paralleled by decreased lean muscle mass and protein intake, so that the serum creatinine and blood urea nitrogen (BUN) may appear to be normal even though there is significant decrease in renal function. The pharmacist may make an approximation of creatinine clearance (CrCl) from stable serum creatinine via the Jeliffe formula for estimating CrCl:

$$\text{CrCl (male)} = \frac{98-0.8\,(\text{age}-20)}{\text{Serum Creatinine (mg\%)}}$$

$$\text{CrCl (female)} - 0.9\text{x}\ \text{CrCl (male)}$$

and classify the patient into mild (CrCl—50-80ml/min), moderate (10-50ml/min) or severe renal impairment (less than 10ml/min) if the kidney has not been subjected to direct insult (nephrotoxic drugs, stones or injury) or indirect injury (shock). A tabulation of recommended dosing intervals from which the above classification has been taken along with the use of nomographic methods for dosing digoxin and gentamicin may help to reduce renal-related adverse reactions.*

The most significant drug interactions involving older patients seem to involve digitalis with diuretics, anticoagulants, anti-infectives and multiple CNS depressant and anticholinergic use. A paradoxical finding in one study of elderly patient is that more neuroactive CNS depressants (analgesics, major tranquilizers and sedative-hypnotics) were prescribed for those patients with superior mentation and minimal physical disability, i.e., the least mentally impaired were the most heavily drugged or "chemically" restrained.

Drugs which change CNS status, blood pressure and/or the cardiovascular system may cause profound changes.

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* A set of three nomograms for dosing digoxin, kanamycin and gentamycin may be obtained from the NOMOGRAMS Business Office, USC school of Medicine, 2024 Zonal Ave., Los Angeles, Calif. 90033 ($3.00)

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STATEMENT OF LONNIE F. HOLLINGSWORTH
BEFORE THE SENATE GOVERNMENTAL AFFAIRS COMMITTEE SUBCOMMITTEE ON GOVERNMENTAL EFFICIENCY, FEDERALISM, AND THE DISTRICT OF COLUMBIA
FEDERAL EMPLOYEES HEALTH CARE COVERAGE AND MAIL ORDER PRESCRIPTION DRUGS

AUGUST 5, 1987

Mr. Chairman, Members of the Subcommittee*:

I am Lonnie F. Hollingsworth from Lubbock, Texas. I serve as the President of National Association of Retail Druggists. With me today are Jim Vincent of Yuma, Colorado, Past President of NARD and the Chairman of NARD's Mail Order Task Force, and John Rector, General Counsel and Vice President of Government Affairs.

Thank you for this opportunity to present the views of the owners, managers and employees of 30,000 independent pharmacies, where more than 75,000 pharmacists dispense 70 percent of the nation's prescription drugs. Together, they serve 18 million persons daily and provide 82 percent of Medicaid pharmaceutical services. Recent reports indicate that prescription drugs account for 60% (41.6 to 78.5%) of a typical NARD member's sales volume. Of course, as you are all familiar, the balance of our members' sales volume includes products such as over the counter drugs, health and beauty aids, sundries, greeting cards, gifts and related products. NARD has long been acknowledged as the sole advocate for the proprietary and professional interests of this vital small business component of the free enterprise system.

NARD members are primarily family businesses. They have roots in America's communities. The neighborhood independent druggist typifies the reliability, stability, yet adventuresomeness that has made our country great.

We are pleased to appear before you today. We would like to express our special appreciation to the subcommittee, its chairman and staff for their assistance in preparation for these hearings.

---

* Jim Sasser (D-TN), Chairman

MAJORITY: (3-D) Senators Sasser, Carl Levin (MI), George Mitchell (ME
MINORITY: (2-R) Senators John Heinz (PA), William S. Cohen (ME)

We are pleased to present our response to the Chairman's inquiries about mail order dispensing operations currently promoted under federal health insurance programs approved by the Office of Personnel Management (OPM) for federal employees and retirees.

We have attempted to address your concerns by presenting our views on:

1) The general subject of mail order prescription drug dispensing;

2) The appropriate regulation of the practice of pharmacy; and,

3) Our specific concerns about the contract between Blue Cross Blue Shield and MEDCO Containment Services, Inc., approved by OPM.

GENERAL CONCERNS

The health consequences of unregulated mail order dispensing are too complex and far too numerous to enumerate. In our view, the bottom line is that mail order firms cannot provide adequate health care to patients they never see. Communication between patient and pharmacist has been a vital component of pharmacy practice since its inception. Pharmacists interact daily with patients in their stores; they monitor their patients' health status, assess their compliance with drug therapy, answer questions, make recommendations, and communicate with their physicians. Patients know they can count on the pharmacist to provide expert advice on drug therapy on the spot and personally attend to their individual health care needs. This face-to-face communication is a key element in ensuring that the public health will be protected.

Understandably, similar concerns have been expressed by public officials about the health care consequences of mail order dispensing. For example, the U.S. House of Representatives Committee on Energy and Commerce in its report "Dangerous Medicine" has called on Congress "to closely examine the mail order dispensing of pharmaceuticals to determine whether or not the public health risks of this growing practice are reasonable."

NARD's Mail Order Clearinghouse, launched in 1985, has collected several hundred examples of the deficiencies inherent in mail order assembly line dispensing. Mr. Vincent will report on these experiences.

REGULATION

The regulation of the practice of pharmacy has been long-established to be exclusively within the purview of state legislatures. The regulation and control of those in a learned profession such as pharmacy is illustrative of the endeavors impacting the public health and welfare which our Constitution and its several amendments reserved to the states.

The respective states consequently have enacted consumer protection statutes and appropriate regulations controlling the practice of pharmacy as a business. Any discussion or consideration of unorthodox dispensing of prescription drugs by out-of-state businesses through the mail must address both the professional and commercial consequences.

Regarding the regulation of this unorthodox method of dispensing prescription drugs, the NARD continues to have serious concerns that the businesses engaging in this type of dispensing fail to comply with rules, regulations and laws in the respective states where they are doing business. These were designed to guard the health of the residents in such states. In the last several years the regulation of such practices has been increasingly considered by state legislature and relevant state agencies.

States have acted to control such unorthodox dispensing from beyond their jurisdiction and it appears are expressing on an increasing basis a willingness to address the public health risks and anticompetitive aspects in even a more comprehensive way. This unorthodox method of dispensing prescription drugs presents a threat to public health, in part, by severing the physician-patient-pharmacist relationship.

States including Arkansas and Louisiana have enacted laws and in the states of Wisconsin and California, Attorneys General have issued opinions addressing the need to license such out-of-state businesses and to regulate the condition of the drugs and prescription medical devices which are sent into a state by such businesses. The Utah Attorney General's office has issued an informal opinion reiterating support for a statute which requires persons advertising the filling or refilling of prescription drugs to residents of Utah to be a Utah licensed pharmacist. This statute, like the others, is even-handed and properly makes no distinction between the state pharmacies and out-of-state mail order businesses. These laws seek only equitable consumer protection of the residents of their states. Other examples includes states that require face-to-face consultation between the pharmacist and the patient, continuing education for pharmacists, expiration dates on the label, or limit the number of technicians who can be involved in the dispensing process so as not to dilute the involvement of the pharmacist who is the prescription drug expert.

After all, the ultimate consumer is not just acquiring a commodity such as a fountain pen or note pad. The proper dispensing of prescription drugs and related matters of patient car are far more comprehensive than the delivery of a commodity. That is why state legislatures have developed comprehensive, rational regulatory schemes such as pharmacy practice acts. One of our primary concerns is that companies both for profit and nonprofit have undertaken an effort to intimidate states to exempt them from such laws and regulations. They mistakenly argue that regulation of the practice of pharmacy and related concerns amount to nothing more than commodities moving in commerce from one state to another. These lobbyists even argue that mail order saves money. At best, this is a close call. Recent studies indicate that, especially with the elderly, costs exceed those of pharmacies. This is in spite of reports that presently mail firms are basically giving the drugs away to build volume in a low-margin, high-volume business.

We have also received reports (for example, California, Wyoming, Virginia and Maryland) that they claim that any effort to subject the mail order businesses to comparable standards for orthodox physician-patient-pharmacist dispensing would violate antitrust laws and that the FTC concurs with this view.

Earlier this year we requested appropriate subcommittees in the House and the Senate to investigate the extent to which a conspiracy has been formed to undermine the application and enforcement of state statutes and regulations designed to protect the consumer and determine to what extent, if any, such activities are being encouraged by the FTC. Laws protecting consumers from the unregulated mail order dispensing were among the areas we cited. Fortunately, appropriate language has been included in both the Senate and the House versions of the FTC authorization legislation to present such intervention by FTC in state activities. Thus these advocates of assembly line dispensing appear basically to want to preempt defacto well-established state laws in order to maintain a competitive advantage.

BLUE CROSS AND BLUE SHIELD

Last fall, we became aware of the intent of Blue Cross Blue Shield to radically alter the nature of the prescription drug coverage for federal employees and retirees. Effective January 1, 1987, covered individuals would be penalized if they attempted to obtain their prescriptions from a pharmacy such as those we represent.

In a nutshell, a preference for a new mail order prescription drug program was established by eliminating the $250 annual deductible, but keeping this deductible for federal employees who continue to patronize a neighborhood pharmacy.

The mail order dispensing is handled by subsidies of MEDCO, including National Rx Services, Inc., of Tampa, Florida.

Anytime the federal government expresses a preference for competitors in our marketplace, our members are concerned. Even if the OPM had not expressed a preference for unregulated and unorthodox dispensing, we have basic concerns about the OPM approval of such preferential contracts. They include the following:

- The contract denies federal employees and retirees the freedom to obtain prescription drugs from the provider of their choice.

- It discriminates against small business competitors.

- By denying these consumers access to local pharmacies, they not only prevent them from utilizing a full service pharmacy, but also deny them access to price competition available in the free marketplace.

Ironically, the Blue Cross Blue Shield promotion of this discriminating program stresses that, "You always have the freedom to choose you own physicians and hospitals, so you have maximum control over the quality of your health care."

We recommend that the preference be eliminated and that OPM fully explain the basis for their approval of the contract and their decision that federal employees not have control over the quality of their pharmacy services. Certainly federal employees should have the same quality of pharmacy services and freedom of choice guaranteed to welfare recipients under federal law.

Additionally, if federal employees are permitted to obtain prescriptions through the mail, we recommend that any federally-approved contract provisions for such services contain provisos requiring that such dispensers abide by the laws and regulations of the employees' and retirees' state. In our view, this will remove such unorthodox dispensing from a "Twilight Zone" type of regulation where, for various reasons, neither the home state or host states monitor the dispensing nor provide an unmistakable forum for consumer complaints and appropriate law enforcement.

CONCLUSION

In conclusion, it's the practice of pharmacy in its full manifestation that provides the reliability and the protection the consumer has grown to and is entitled to expect. Our members interact with more than 18 million customers a day, and it's these interactions which have led year-in and year-out for the public to select pharmacists, retail druggists, as the most trusted secular profession. To state the obvious, these essential trust relationships were not developed through the mail box.

On behalf of the Officers, Executive Committee, and members of the National Association of Retail Druggists, we thank you for the opportunity to appear before this subcommittee. We look forward to working with the Committee to help assure that future prescription drug benefit programs approved by OPM do not discriminated against the consumer and small business.

NARD OFFICERS
LONNIE F. HOLLINGSWORTH, P.D., PRESIDENT
8119 - 34th STREET, LUBBOCK, TX 79410
D. J. WILLIAMS, P.D., PRESIDENT-ELECT
611 SECOND STREET, WEBSTER CITY, IA 50595
DONALD L. MOORE, P.D., FIRST VICE PRESIDENT
610 WEST MARKLAND AVE., KOKOMO, IN 46901
GENE GRAVES, P.D., SECOND VICE PRESIDENT
99 BENT TREE, LITTLE ROCK, AR 72212
KENNETH B. EPLEY, P.D., THIRD VICE PRESIDENT
1120 COMMERCIAL STREET, S.E., SALEM, OR 97302
DENNIS L. LUDWIG, P.D., FOURTH VICE PRESIDENT
4700 BASELINE ROAD, BOULDER, CO 80303
W. WHITAKER MOOSE, P.D., FIFTH VICE PRESIDENT
P.O. BOX 67, MT. PLEASANT, NC 28124
JOHN H. VANDEL, P.D., SECRETARY-TREASURER
2041 MAIN STREET, TORRINGTON, WY 82240

NARD EXECUTIVE COMMITTEE
DONALD W. ARTHUR, P.D., CHAIRMAN
366 SOMERVILLE, TONAWANDA, NY 14150
JOSEPH A. MOSSO, P.D.
319 CAROLYN AVENUE, LATROBE, PA 15650
WILLIAM S. KATZ, P.D.
26 STAGE COACH LANE, NEWINGTON, CT 06111
CALVIN J. ANTHONY, P.D.
626 SOUTH WALNUT STREET, STILLWATER, OK 74074
LAWRENCE E. SCHREIBER, JR., P.D.
2906 NEWBRIDGE COURT, ST. LOUIS, MO 63129
WILLIAM L. SCHARRINGHAUSEN, P.D.
BOX 29-D, PARK RIDGE, IL 60068

CHARLES M. WEST, P.D.
EXECUTIVE VICE PRESIDENT

THE NATIONAL ASSOCIATION OF RETAIL DRUGGISTS
205 DAINGERFIELD ROAD, ALEXANDRIA, VA 22314
(703) 683-8200

September 4, 1987

Ms. Denise A. Botsaris
Chief Clerk
Subcommittee on Government
Efficiency, Federalism, and the
District of Columbia
Committee on Governmental Affairs
United States Senate
Washington, DC 20510

Dear Ms. Botsaris:

The purpose of this correspondence is to respond to questions submitted by you on behalf of Senators Heinz and Mitchell to Mr. Lonnie Hollingsworth, regarding the August 5-6 hearing on the Safety and Soundness Standards of the Mail Order Drug Industry.

Question by Senator Heinz:

To support your contention that mail service pharmacists cannot provide adequate health care to patients they never see, underlying the importance of a strong physician-patient-this allegedly deficient health care which compare, for instance, the actual time spent on patient-pharmacist and/or pharmacist-doctor communication -- whether in person, over the phone, or by letter -- by retail pharmacists to that by mail service pharmacists?

Answer:

The traditional relationship between a physician and pharmacist is a professional one, a hands-on one -- health care professionals who know one another, their strengths and weaknesses, and the manner in which each practice their respective profession. It is this interpersonal relationship

Answer:

It is our view that the practice of pharmacy, especially unorthodox methods such as dispensing prescription drugs through the mail, ought to be regulated by the consumer protection statutes in the states of the patients receiving the mail order drugs. Presently, it is our view that mail order dispensing of prescription drugs is virtually unregulated in that typically, neither the state out of which the mail order outfit operates nor the states to which they are extending the practice of pharmacy, regulate the dispensing of these prescription drugs. At a minimum, any federal contract for the providing of prescription drugs, for example Blue Cross Blue Shield/Medco contract for federal employees and retirees, should be required to meet the same standards of pharmacy practice required for our members in the respective states where their patients receive prescription drugs. Beyond that, it is our recommendation that all practice of pharmacy, vis-a-vis the mail, be required to meet such standards. After all, can you imagine a California lawyer or physician attempting to practice his or her profession in Pennsylvania without meeting the requisite Pennsylvania standards of practice including familiarity with consumer protection statutes and regulations.

Once again, we appreciate the opportunity to participate in the Subcommittee's investigation and look forward to working to assist the Subcommittee and its staff in fashioning the appropriate legislative response.

With warm regards,

John M Rector

John M. Rector, Esq.
General Counsel & Vice President
Government Affairs

JMR/mbs

Tennessee Pharmacists Association
ORGANIZED 1884
OFFICE OF EXECUTIVE DIRECTOR
226 CAPITOL BLVD. NASHVILLE, TENN. 37219

STATEMENT TO THE
COMMITTEE ON GOVERNMENTAL AFFAIRS

Subcommittee On
Government Efficiency, Federalism, and the
District of Columbia

by

James H. McMahon, Jr.
Oak Ridge, Tennessee
and the
Tennessee Pharmacists Association

(615) 256-3023

Mr. Chairman:

I am James H. McMahon, Jr., an independent community pharmacist from Oak Ridge, Tennessee. My family has practiced pharmacy in Oak Ridge for 30 years.

Oak Ridge is a Tennessee city with an unusually large population of federal employees, many who are our patients. I and my colleagues are gravely concerned about the lack of adequate health care services being made available to federal employees. In recent months, the Office of Planning & Management has instituted a mail-order prescription program for federal employees. This plan adversely impacts the workers' health status by:

1) Denying freedom of choice for the provision of prescription drug services. This is accomplished by lack of first dollar coverage for those not choosing the mail order option.

2) Removing a system of checks and balances within the physician-patient-pharmacist relationship. The checks and balances system works to the patient's advantage when health care providers are local, know the patient personally, know first hand the patient's life style, medical history, self-treatment tendencies, and social habits which impact health status.

3) Denying the protection afforded all Tennessee citizens against non-approved product selection. The State of Tennessee has a very stringent product selection law which requires all drugs to be specifically approved by Tennessee standards before being eligible for product selection. When prescriptions are dispensed outside of Tennessee other state laws govern the act and do not provide the protection intended by the Tennessee legislature (TCA 53-10-204).

4) Exposing patients to the unwarranted risk of using deteriorated medications. Mail systems do not provide the environmental control or security required by many medications to retain their potency and effectiveness.

5) Encouraging the stockpiling of medications through the ordering and dispensing of large quantities of drugs. The potential for overuse or accidental poisoning of children in the home is escalated.

6) Denying the patient access to emergency prescription service or advice. Immediate access to a health care provider is essential at times of adverse reactions or unexpected reactions to newly prescribed medications. Because of liability concerns it is difficult for the local health care provider to provide advice since they are not responsible for the total health care of the patient.

7) Increasing the cost of health care for each worker through over-utilization, lost medications, provision of large quantities of medications to which a patient reacts and must discontinue. Also, current plans do not cover first dollar costs for those patients who choose to receive their services locally.

8) Reducing the availability of pharmacy services in a given area. Pharmacists cannot, either from a professional or business view, supply just the high cost, low utilization products and services which mail order operations do not want to provide.

9) Delaying initiation of therapy when the prescription does not contain all of the required information. One third party states "If a prescription is missing information, a pharmacist will attempt to call your doctor....." Attention is drawn to the word "attempt". What happens to therapy if the prescription is returned to the patient to secure the required information?

10) Circumventing the control provided by the Control Substances Act. In a federal program refill slips are issued for medications for which refills are authorized. When refill slips are lost, the patient need only call a toll free number to have a new slip issued. What happens to the patient who is predisposed to drug abuse or over-utilization? Does this system protect from controlled substances being secured by family members or persons who "find" refill permission slips?

11) Encouraging unsafe requests of physicians. A Federal plan encourages patients to ask for two prescriptions of medications which must be started immediately. The first for use at a local pharmacy, the second for the mail order service. If patients obtain two supplies, they may have a stock pile of medications to use at a later date when similar symptoms occur. Subsequent treatment may be initiated without any health care provider involvement. Similar symptoms do not necessarily indicate similar causes or treatment. Is this good health care?

Specific examples of all the above situations can be cited. In Tennessee, specific examples include:

1) Delayed delivery (waiting weeks for a supply of medication).

2) Patient inconvenience and expense (patient had to call mail order service three times at his expense before medication was received).

3) Incomplete supplies of medications provided.

4) Medications unprotected (insulin arrived in a warm bottle).

5) Patient charges for health care increased (additional office visits required for patients to receive prescriptions as required by program).

Because of these identified patient care concerns, I believe the government should review all aspects which resulted in this dramatic change in the delivery of health care services to federal employees. For the benefit of the employee, provision of health care must be returned to the local level where the physician-patient-pharmacist relationship is maintained and where services are provided in the most cost effective manner possible.

In conclusion, I firmly believe that it is impossible for mail order pharmacies to provide the quality of service that the public deserves and demands, nor do I believe that it is fair to retail pharmacy to be left with the acute care and community responsibilities while a few enterprising businessmen skim the cream from retail pharmacy while pading their own pockets and providing inadequate pharmacy services.

Respectfully,
James H McMahon Jr
and the
Tennessee Pharmacist Association

TESTIMONY OF DEL BARTON ROWE, ATTORNEY AT LAW FROM THE STATE OF UTAH BEFORE THE COMMITTEE ON GOVERNMENTAL AFFAIRS

THE HONORABLE JOHN GLENN, OHIO, CHAIRMAN
AND
THE HONORABLE JIM SASSER, TENNESSEE, SUBCOMMITTEE, CHAIRMAN

Dear Messrs. Glenn and Sasser and Committee Members:

I am Del Barton Rowe a private practitioner from the State of Utah and I am the attorney for the Utah Pharmacuetical Association.

The Utah Pharmaceutical Association represents approximately 1500 pharmacists and 375 pharmacies in the State of Utah. Together this group of pharmacists serves approximately 2,000,000 people living in Utah.

Most of these pharmacies are family businesses and are what I consider "core free-enterprises" in America. However, there are three to four hundred pharmacists who work for drug or grocery chain stores and they are also are included in my representation. The typical Utah pharmacist operates as a small business, employs several employees, pays numerous different taxes and in essence is one of the few "pure" tax supporters left in America. The burden seems to fall most heavily on the privately-owned self-employed these days.

MAIL ORDER PHARMACY

My principal testimony today is one as a friend to the Utah pharmacists. When I first came aboard with the Utah association as attorney in January 1986, I was handed a list of several problem areas for the Association. In the next several months of study and observation it occured to me that the same thing was about to happen and was happening to these pharmacists concerning mail order pharmacy as happened to attorney's with the advent of real estate agents doing deeds, trust deeds, mortgages, etc. along with banks doing wills, trusts, and other estate planning documents. Today in my profession over one-third of our duties are now being done by a non-traditional person who is a layman. As I observe Utah state pharmacists and mail order, I could see that as I said to the pharmacy convention last April, "You students instead of wearing a white smock, will need to get on the blue walking shorts, knee length blue socks, black shoes, and short sleeved shirts because as a postman you will be delivering more prescriptions to the people of Utah than you would as a pharmacist. It is estimated that over $5,000,000 is being spent per year by third party insurance companies and the citizens themselves to out-of-the-state (of Utah) sources for drugs by mail order.

Perhaps the most alarming observation about mail order is the method of delivery. If you think about it, there is no more unsecure, loose, dangerous, or theft-prone procedure than to have the United States Postal Service put a sensitive prescription in an open mail box outside someone's home for the whole world to see. More than 50% of the homes in Utah have mail boxes that are placed on the street for easy delivery by postal mail "jeeps". These mail boxes are open and unlocked and are subject to neighborhood play, valdalism, heat, cold, and other obvious dangers.

DANGER TO THE HEALTH, SAFETY AND WELFARE OF OUR UTAH CITIZENS

The intergity of the mail order system is apalling. The following cases make the point:

CASE NUMBER 1

The wife of a Brigham Young University faculty member was a "brittle" diabetic. In 1986, this woman was on the LDS church's mail order program and was supposed to be recieving adequate insulin shipments because her third party provider the Deseret Mutual Benefit Association, would only pay for her insulin if she ordered it through the mail order program. In the heat of the summer of 1986, her insulin was sent to Utah and in the 110 degree heat both in the United States Postal Service trucks and her mail box, the insulin deteriorated, did not do the job and this woman went into a diabetic coma. To add insult to injury, to the Utah pharmacist who previously took care of her before the mail order program, her husband in this emergency situation had their "former" pharmacist open up his drug store and furnish them with fresh insulin which brought her out of the coma and restored her insulin balance. Mail order pharmacy provides no in transit refrigerated service for heat sensitive medications that I know of, especially in the mail boxes of Utah citizens.

CASE NUMBER 2

This second case involves the wife of a Brigham Young University Professor who suffered from high blood pressure who was also on the same Deseret Mutual Benefit Association health program. She was also required to order her blood pressure medication from an out-of-state mail order pharmacy. In this case, because of the mail order program, her physician issued two prescriptions which is becoming a common practice here in Utah. One prescription for the immediate needs and a second prescription for mail order drugs are often not delivered for a two to three week period. In this case the doctor's first prescription was for 30 capsules of SECTRAL a beta-blocker which was in fact filled at a local drug store. The second prescription was for 180 capsules which this woman sent to the mail order house required by the this program. After taking the first few capsules of SECTRAL this woman had an instant severe reacion to the drug and was immediately taken off them by her doctor. However, the 180 capsules arrived paid by the third party provider at a cost of $86.05 which were never used and could not be returned because of the no-return policy on dispensed prescriptions.

CASE NUMBER 3

The Dean of one of the major departments of Brigham Young University suffers from arthritis. In this case the prescription was issued by the doctor and sent by the patient to the out-of-state mail order house for filling. But the supply of arthritis medication did not arrive the first week, did not arrive after the second week, and he was in such pain that he also had to have the local pharmacist open his store so he could buy enough NAPROSYN to tide him over until his order arrived. The bigger problem in this case is that this gentlemen had no prescription to give to the local pharmacist and yet expected him to provide the NAPROSYN for him, frankly in violation of the Utah Pharmacy Practice Act. Drugs cannot delivered in Utah to a consumer without a prescription. He ended up paying double fees for the priviledge of being on the mail order program.

CASE NUMBER 4

This case involves the Veteran's Administration Mail Order Prescription program. This veteran suffered from extremely high blood pressure and diabetes. In this instance, the prescription was sent by mail and the supply was not delivered the first week, nor the second week, nor the third week. Then when the patient was is in trouble and was about to be hospitalized as he had run out of his medications he called Dale Loveridge, a local pharmacist, and had him open up his pharmacy, after hours, to get blood pressure medication and DIABANESE an oral hypoglycemic for his diabetes. At that time he had been out of both medications for 10 days and was rapidly approaching the diabetic coma stage. This added to his blood pressure problem could have been fatal according to this pharmacist. This sad commentary on mail order pharmacy service is expressed in the veteran's comment, "I can never depend on these guys getting me my drugs on time."

CASE NUMBER 5

1986 - Reported to Mr. C. Neil Jensen, Executive Director, of the Utah Pharmaceutical Association, where a group of elderly couples lived in the same apartment complex. They were also on the DMBA program and at one time had shelves and stacks of mail order drugs put in a common place where everyone who lived in the apartment building could come and help themselves. Drug interaction and serious injury are obvious in this instance.

UNFAIRNESS OF THE AMERICAN ASSOCIATION OF RETIRED PERSONS

Perhaps one of the most unfair and most incidious programs ever foisted on the American people and the American pharmacists is the AARP Pharmacy Services program. A lot of our Utah pharmacists are in private family enterprises operating on a shoe string with no government subsidies or government help, but are burdened with considerable government taxes. Yet, the United States Government has conspired with AARP to do damage to these choice families and these great American pharmacists. AARP for example receives an annual federal postage subsidy of approximately 6.5 million dollars. The AARP has no business competing in the pharmacy marketplace unless it pays the full cost of business just like our people do. Let me show you the typical AARP Pharmacy Service catalog sent out to millions of American people in direct competition to our local pharmacists. On page 3 is the example of their prescription drug program where people are urged to buy their prescription drugs through the mail. Now look at the other approximately 140 pages of advertisement for products to be sold by AARP in direct competition with each and every local pharmacy in the state of Utah and every state in America. Where is the fairness here friends? Also the tax dollar is not collected as the mail order company is out-of-state and doesn't pay taxes in Utah.

AARP'S STAB IN THE EYE WITH THE UTAH STICK

In 1986 AARP attempted to set up a mail order house in the State of Utah. They came in with all guns blazing to the Utah State Board of Pharmacy for permission to operate a pharmacy in the state of Utah. However, AARP intended to violate the Utah laws concerning the pharmacist to technician ratio as required by Utah Pharmacy Practice Act 58-17-10 of the rules: SUPPORTIVE PERSONNEL OR TECHINICIAN . . . (2) Supportive Personnel or Technicians shall not exceed a ratio of one-to-one with a registered pharmacist while assisting a pharmacist in RX filling. Yet AARP threatened the state board with lawsuits, embarassed Governor Norm Bangerter by accusing his administration of foot dragging, and talked the Salt Lake Area Chamber of Commerce into supporting their (AARP's) push for a Utah mail order house and in the end totally embarassed and threatened Governor Bangerter's administration. This was so because Utah State law requires a one to one ratio yet AARP knows that it cannot profitable operate a mail order pharmacy unless it has a disappropriate number of technicians to one pharmacist. Typically a pharmacist with five years of technical professional education demands much higher pay than a high-school dropout or a retired railroad worker which can be hired as a technician.

MAIL ORDER HOUSES TO COUNSEL PATIENTS

It appears to me to be virtually impossible for out-of-state mail order houses to properly counsel their clients. Utah law Section 58-17-12 (D) states that "the pharmacists or licensed intern counsels the patient on the use and expected response to the prescribed drug" further section 58-17-2 (33) (g) the practice of pharmacy includes providing information on drugs or devices which may include but is not limited to advise relating to therapeutic values potential hazards and uses, (h) drug product substitution, (i) supervision of pharmacists and supportive personnel and (j) counseling of patients concerning adverse and therapeutic effects on drugs.

As far as I know with the obvious long distance charges and lack of personnel, I cannot believe that drugs coming through the mail can result in counseling as compared with face to face confrontation with expert, qualified, caring, local pharmacists which people depend on and trust.

UTAH LAW REQUIRES COMMUNICATION BETWEEN THE PATIENT AND/OR PRACTITIONER WITH THE PHARMACIST BEFORE SUBSTITUTION IS ALLOWED

In most instances I know of, substitution is often made by mail order houses as a normal and standard procedure. However, Utah law requires that substitution if any, shall be communicated to the purchaser prior to the sale.

Mail order interstate drug sales are unfair because out-of-state drug houses do not comply with the local Utah law.

FEDERAL EMPLOYEES MAIL ORDER HEALTH PLACE HURT UTAH PHARMACISTS

Federal Employees, through Blue Cross Blue Shield announced in 1986 their new health plan which includes mail order pharmacy services. This is a hard "pill" for our pharmacists to swallow for our pharmacists have to pay for these employees salaries and benefits with their hard earned tax dollars and then subsidize these health care plans at the same time. To have these federal employee plans unfairly compete with local Utah pharmacists is ridiculous.

Regarding health and safety, the federal employee number given on their handout, which is before you,1-800-554-6800 operator 200 has been disconnected. Perhaps someone here can tell me how counseling can go on with a out-of-state mail order house such as this without any way to even reach counsel.

UTAH ATTORNEY GENERAL PROSECUTING MAIL ORDER HOUSES

March 16, 1987 the Utah Attorney General in his informal opinion 87-3 came down hard on out-of-state mail houses. These law offenders were, through local third party insurance companies, mailing brochures advertising the sale of prescription drugs. It is a criminal act in the state of Utah to advertise for the filling or refilling of prescriptions for patients or consumers unless that person who is doing the advertising has first been granted a license to practice pharmacy in Utah. 58-17-10 (1) (j) The attorney general's opinion goes on to state "the statute makes no distinction between in-state and out-of-state RX. Notably there is no statutory exemption for out-of-state mail order pharmacies. The licensure requirement applies to both out-of-state pharmacies which regularly solicit orders from Utah residents as well as businesses and pharmacies that desire to advertise their services to the public. By requiring a person to become licensed prior to adveritisng under section 58-17-10 (1) (j), the Utah Legislature is not barring out-of-state mail order pharmacies from doing business in this state, it simply is requiring that the pharmacies become subject to this state's pharmacy regulations in order to effectuate the State's keen interest in protecting the public's health and safety. The licensure requirement also promotes the State's interest in monitoring drug distribution in Utah. Nothing more or less is required of out-of-state pharmacies than is required of in-state distributors. Section 58-17-10 (1) (j) thereby applies evenhandedly to all prospective advertisers and distributors of pharmaceuticals whether they are residents or non-residents of Utah.

All we ask for is fairness. It is really fair for out-of-state non-licensed pharmacies, especially federal government or federally subsidized programs like AARP, to advertise in the state of Utah when unlicensed people or organizations in the state of Utah cannot by law advertise either. Why should such a tremendous advantage be given to an out-of-state outfit particiularly when they are beyond the jurisdiction of the police power of the state of Utah. It happens to be a class A misdemeanor with a fine of up to $2500.00 and/or a year in prison for each piece of mail sent into the state of Utah by these health plan promotors and others, including AARP.

Cease and Decist orders or letters have been sent to approximately 12 violators including the following:

Federal Employees Blue Cross Blue Shield - Federally Subsizided

AARP - Mailings Federally Subsidized

Retired Persons Pharmacy Services

Arthtiris foundation - Mailings Federally Subsidized

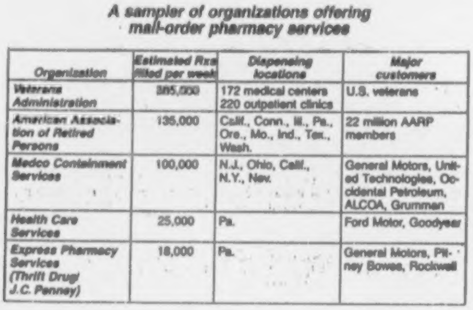
Postal Supervisors Health Benefit Plan - Federally Subsizided

Utah Local Government Trust - Subsizided by Local Governments

Equitable Life and Casualty

Deseret Health Care Program Discount Pharmacy Service (Non-Profit)

By the way, Blue Cross Blue Shield first received tax-exempt status and they now enjoy, as a non-profit organization, "a competitive advantage" over for-profit health insurance companies. Therefore, this non-profit advantage, coupled with the power of federal subsidies, gives these listed programs tremendous advantages over private pharmacies.



A sampler of organizations offering mail-order pharmacy services

Organization	*Estimated Rxs filled per week*	*Dispensing locations*	*Major customers*
Veterans Administration	385,000	172 medical centers 220 outpatient clinics	U.S. veterans
American Association of Retired Persons	135,000	Calif., Conn., Ill., Pa., Ore., Mo., Ind., Tex., Wash.	22 million AARP members
Medco Containment Services	100,000	N.J., Ohio, Calif., N.Y., Nev.	General Motors, United Technologies, Occidental Petroleum, ALCOA, Grumman
Health Care Services	25,000	Pa.	Ford Motor, Goodyear
Express Pharmacy Services (Thrift Drug/ J.C. Penney)	18,000	Pa.	General Motors, Pitney Bowes, Rockwell

All in all the total number of Utah citizens being inundated with advertising from the aforementioned plus several more, probably exceedes over 200,000 Utah citizens. We have here a situation where street side Utah mailboxes are potential unmanned pharmacies. We must ask ourselves a very hard question: Do we really think that below zero winter temperatures or 110 degree heat in the summer are condusive to helping the effectiveness of drugs delivered into our street side boxes?

SALT LAKE AREA CHAMBER OF COMMERCE PROPOSED RESOLUTION

On March 10, 1987 a resolution was presented to the Board of Governors of the Salt Lake Area Chamber of Commerce. This resolution is attached to this presentation in which this committee is seriously urged to consider the harm and danger of mail order pharmacy, not to mention economic loss. The resolution is still under consideration as the Chamber is waiting for a vote by the Utah Medical Association as to its support of a similiar resolution in its September College of Delegates meeting. I like the following statement in the resolution:

> "Mail Order Pharmacy" takes away the required duty and responsibility of pharmacists to counsel their patients on proper use, drug interactions, side effects, allergic reactions, and maintaining patient profiles. Mail Order pharmacy breaks this time honored triangle (between doctors - hospitals - pharmacists) of professional health care. Further, mail order opens up the opportunity for drug abuse, illegal drug sales, drug swapping, and forgeries of doctor's prescriptions, etc.

The resolution goes on to conclude with the following statement:

> The Salt Lake Area Chamber of Commerce hereby resolves to encourage health insurance and health care organizations to refrain from soliciting our Utah people to buy drugs through the mail out-of-state, and otherwise comply with the Utah Law.
>
> We further resolve to encourage our fellow citizens to use the time honored profession of pharmacy as it pertains to counseling and protection in the use of drugs and help our people avoid harmful drug abuse and misuse which in enhanced by the use of mail order pharmacy.

HEAVY HANDED THREAT OF CRIMINAL PROSECUTION BY FTC

It was reported by the counsel to the California Pharmacists Association that either a member of the FTC or other spokesman for FTC appeared before the California State Board of Pharmacy which enforces pharmaceutical practice in the state of California and gave them a serious threat, that if they attempted in any way to curtail the free use of the mails for mail order pharmacy or to restrict in any way any company using mail order, that the FTC would seek criminal prosecution of those individuals. This threat is particiularly offensive because it raises the constitutional issue which hangs over this mail order pharmacy issue. That issue if whether any restriction of mail order pharmacy violates the commerce clause of the United State Constitution. However, may I just state that as our Attorney General said, "The regulation of pharmacies has been recognized as a legitimate exercise of a state's police power. (Cases cited.) Such regulation is consistent with the broad police power which rests with states to ensure the public's health, safety and welfare. . ."

CONCLUSION

In this whole scenario, all that Utah pharmacists request is to be treated fairly by this body. If mail order pharmacy companies from out-of-state are to operate in Utah, they should comply with the same law that our Utah pharmacists are required to. We should encourage and pass legislation which would require all interstate mail order houses to comply with the laws that exist in the local states. Mail order houses should not be given any advantage commercially, professionallly or otherwise over the local state pharmacists. The federal subsidizes AARP and the arthritis foundation receive, should be immediately stopped. The unfair advantage given these organizations over our Utah pharmacists is indeed unfair and invalidates the integrity of the pharmacy system in America. It also creates severe economic hardship on those sustaining our government in the free enterprise system. Ask mail order pharmacy houses what they intend to do about complying with the protection statutes and regulations previously mentioned in this presentation.

What do mail order houses intend to do about the predicament they place our local pharmacists in when the consumer is forced to buy his products through the mail? Third party providers are taking the business out of the front door of our pharmacists and then expect these same pharmacists to answer the dozens of questions people have to call about daily. Perhaps we should tell our pharmacists to bill the mail order houses for their patient counseling. That is the bottom line of this presentation. Does mail order pharmacy serve the health and welfare of our citizens and provide the intergity which has been an inherent part of this indispensable profession.

What do our people do until the mediation arrives? What do the people do when their medication is stolen? What do they do if the medication is lost? What do they do if they run out of medication? What do they do with larger than normal quantites when the medicaiton is changed by the doctor. Shouldn't your pharmacist and doctor be involved in selecting your drugs vs. having an insurance carrier demand that you only buy your drugs on a specific list from an unknown out-of-state outfit that you do not know and for whom you do not even have a phone number?

I appreciate this priviledge and wonderful opportunity to appear before you. I come to you primarily as a private citizen alarmed at the incrosion of government and conspiricaries against my brothers, the pharmacists. I have also spoken to you as a professional and as the attorney for the Utah Pharmaceutical Association made up of hard-working employed American citizens who are the heart of this great nation. All we are asking is to be treated fairly and the fairest treatment would be to require mail order houses to comply with our laws and respect our laws as states and our state associations. If local pharmacists are expected to abide by the laws of our state's then so should mail order houses on an equal basis. Finally, the government and its employee health programs should get out of the pharmacy business and put it back where our forefathers intended it to be. I refer simply to free enterprise.

Attached hereto are two proposed senate bills to help mail order pharmacy and third party providers conform to the laws and regulations of the respective states. Proposed Senate Rule #1 - REQUIRE ALL MAIL ORDER FIRMS TO COMPLY WITH STATE LAWS IN ALL RESPECTS. This would put them on an equal basis with individual state pharmacies. Senate Rule #2 - RESCIND THE AARP AND ARTHRITIS FOUNDATION AND OTHER NON-PROFIT ORGANIZATIONS POSTAL SUBSIDIES WHERE THEY ADVERTISE THE SELLING OF BOTH PRESCRIPTION AND OVER THE COUNTER DRUGS IN DIRECT COMPETITION WITH THE LICENSED PHARMACIES PRACTICING IN INDIVIDUAL STATES.

Thank you again for this opportunity and may the Lord bless you to carry out your duties in an inspired manner for the blessing of this wonderful land of ours.

Thank you.

RESOLUTION
Board of Governors
Salt Lake Area Chamber of Commerce
March 10, 1987

WHEREAS: A time honored professional relationship of trust and confidence, has existed historically between Doctors, Hospitals, and Pharmacists for the health, safety and protection of our citizens.

WHEREAS: Several health care organizations and insurance companies have now inundated our Utah population with advertisements and solicitations telling our citizens to buy their prescription and over-the-counter drugs from out-of-state vendors through the mail. In other words patients send their doctor's prescriptions by mail to out-of-state companies to be filled.

WHEREAS: "Mail Order Pharmacy" takes away the required duty and responsibility of pharmacists to counsel their patients on proper use, drug interactions, side effects, allergic reactions, and maintaining patient profiles. Mail Order pharmacy breaks this time honored triangle of professional health care. Further, mail order opens up the opportunity for drug abuse, illegal drug sales, drug swapping, and forgeries of doctor's prescriptions, etc.

WHEREAS: Doctors and patients lose the pharmacist's expertise, monitoring, accessability and personal confidence when they use mail order vendors. Mail order vendors provide little or none of these.

WHEREAS: Per year, it is estimated that currently over four million dollars in prescription business and untold millions for non-prescription drugs will be spent out-of-state by our citizens thus undermining an already fragile Utah economy and further eroding our tax base. The sales tax loss is in the hundreds of thousands already.

WHEREAS: It is against the law to adverstise in Utah for the sale of prescription drugs unless one is a licensed pharmacist. Most of the advertising for mail order is being done by unlicensed health insurance groups and health organizations. The Attorney General's Office of the State of Utah is now beginning to enforce the following law: Utah Code Section 58-17-10 Class A Misdemeanor "(1) It is unlawful for any person to: (j) . . . advertise the filling or refilling of prescriptions for any consumer or patient residing in Utah if that person is not licensed. . ."

THEREFORE: The Salt Lake Area Chamber of Commerce hereby resolves to encourage health insurance and health care organizations to refrain from soliciting our Utah people to buy drugs through the mail out-of-state, and otherwise comply with the Utah Law.

We further resolve to encourage our fellow citizens to use the time honored profession of pharmacy as it pertains to counseling and protection in the use of drugs and to help our people avoid harmful drug abuse and misuse which is enhanced by the use of mail order pharmacy.

INDEX - CURRENT MAIL ORDER ADVERTISEMENTS

Blue Cross/Blue Shield - Federal Employees

Deseret Mutual Benefit Association - LDS Church Employees

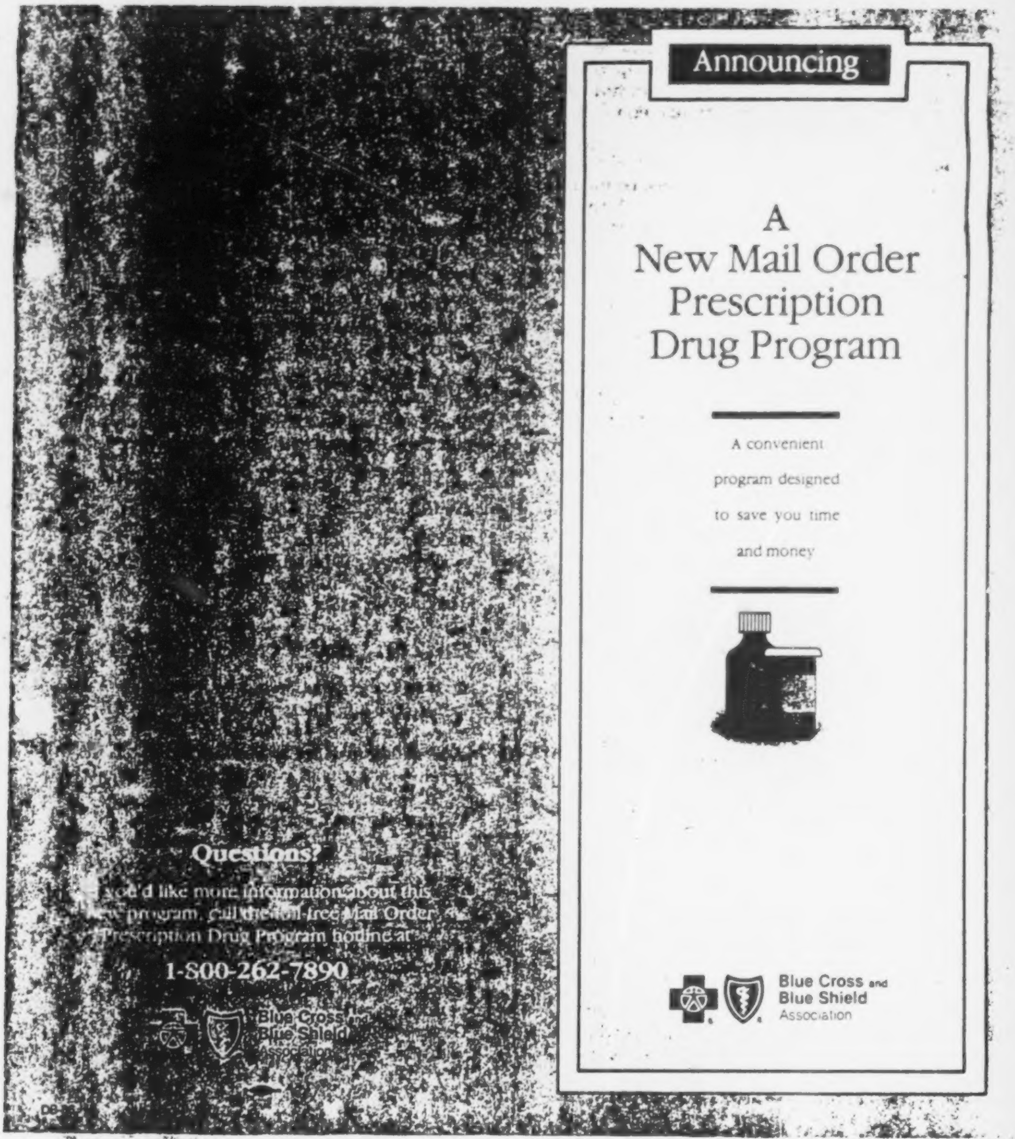
Blue Cross/Blue Shield - Public

Utah Local Governments Insurance Trust - Local Government Employees

Walgreens - Mutual of Omaha - Federal Employees

Equitable Life - Policy Owners

Mutual of Omaha - Postal Supervisors



Questions?

If you'd like more information about this new program, call the toll-free Mail Order Prescription Drug Program hotline at

1-800-262-7890

Blue Cross and
Blue Shield
Association

Announcing

A
New Mail Order Prescription Drug Program

A convenient
program designed
to save you time
and money

Blue Cross and
Blue Shield
Association

Beginning in 1987, a new Mail Order Prescription Drug Program will be added to your Blue Cross and Blue Shield Standard Option or High Option coverage. This program is designed to save you both time and money if you use prescription drugs on an ongoing basis.

For a prescription to qualify for this new Mail Order Prescription Drug Program, it must be for at least a 21-day supply, and no more than a 90-day supply, plus refills. Prescriptions will be mailed to you at your home, and the cost to you is only $5.00 per prescription if you have Standard Option coverage, and $3.00 if you have High Option coverage. Subscribers who have Medicare Part B pay nothing for their prescription drugs under this program.

Why is the Mail Order Prescription Drug Program important to me?

- **Convenience:** You and your family members can order prescription drugs and have them mailed directly to your home, postage paid.
- **Cost:** The only cost to you is $5.00 per prescription for Standard Option and $3.00 per prescription for High Option subscribers. Subscribers who have Medicare Part B pay nothing for their prescription drugs. When you purchase drugs through the Mail Order Prescription Drug Program, your purchase is not subject to the calendar year deductible.
- **Information:** You will receive an annual summary showing all prescriptions dispensed under the program to members of your household.
- **Service:** You will be able to telephone, toll-free, Mail Order Prescription Drug Program customer service representatives if you have questions about your prescriptions.

What is covered?

- Only drugs for which your doctor has written a prescription as required by federal law.
- Birth control pills, weight control pills, drugs used for experimental purposes, and drugs which may be purchased without a prescription are *not* covered by this program.

Who is eligible?

- You and your family members who are enrolled in the Blue Cross and Blue Shield Service Benefit Plan in 1987 are eligible for the Mail Order Prescription Drug Program.

How will the program work?

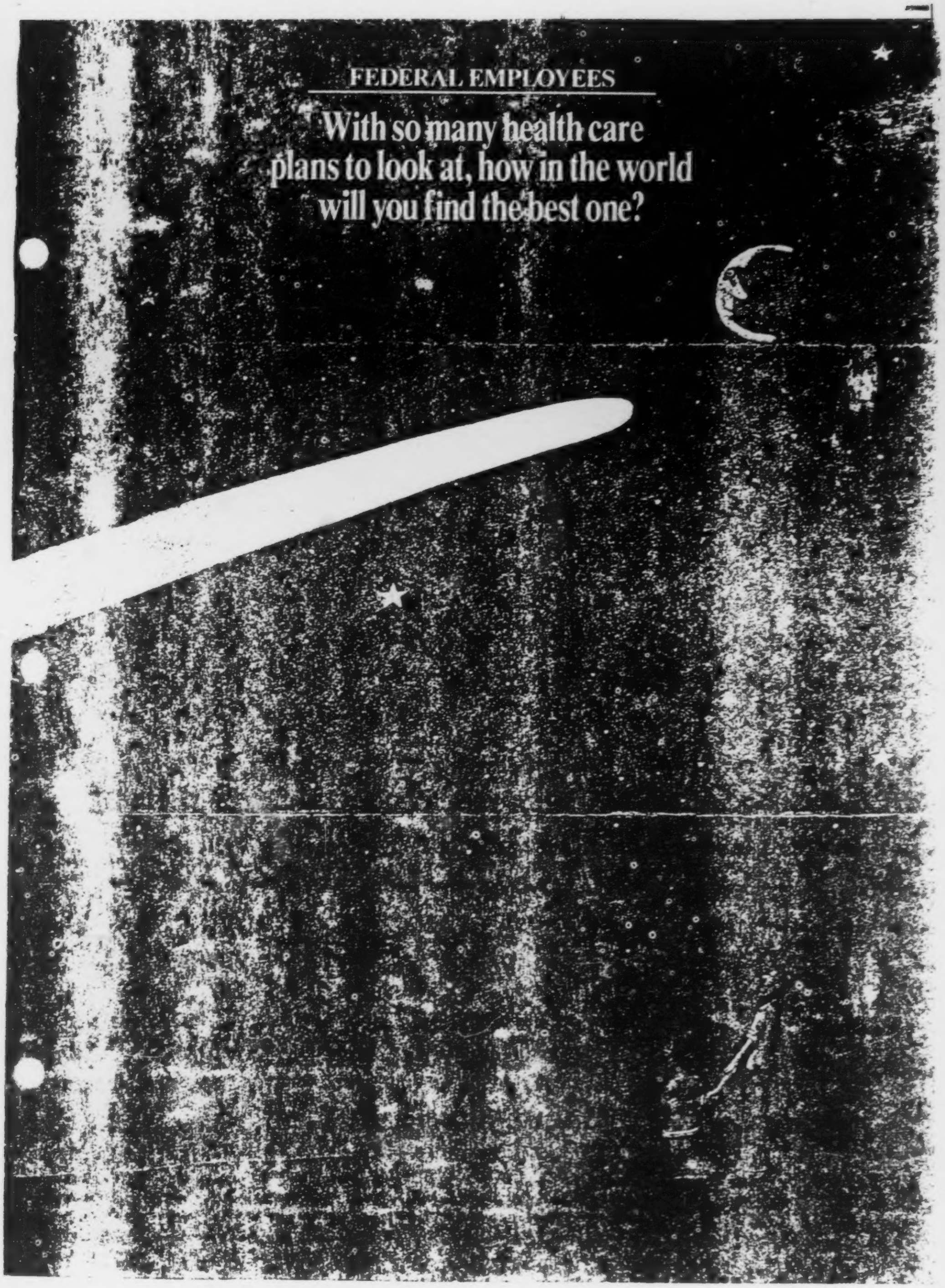
- In mid-December you will receive a description of the program and an order form from the pharmacy we've chosen to provide the mail order prescription service.
- If you are taking medication on an ongoing basis, ask your doctor for a new prescription for up to a 90-day supply, plus refills.
- After December 29, mail your prescription, the completed order form and your copayment to the Blue Cross and Blue Shield Mail Order Prescription Drug Program in the pre-addressed envelope that will be provided. DO NOT MAIL YOUR FIRST PRESCRIPTION UNTIL AFTER DECEMBER 29, 1986.
- Your order will be processed and your medications will be sent to you via First Class Mail or UPS along with instructions for future refills with another order envelope.

How do I order refills?

- With the original prescription medication, you will receive information showing the number of times your doctor has said it may be refilled. To order refills, mail the refill notice in the order envelope along with your payment for each refill.

What about Generic Drugs?

- The generic name of a drug is its chemical name. The brand name is the trade name under which the drug is advertised and sold. By law, generic and brand name drugs must meet the same standards for safety, purity, strength and effectiveness. When your doctor prescribes a generic drug or authorizes a generic substitution, it permits the pharmacist to dispense a generic drug. Generic drugs will be dispensed in accordance with your wishes and the wishes of your physician.


FEDERAL EMPLOYEES
With so many health care plans to look at, how in the world will you find the best one?

Excellent hospital benefits. With the high cost of hospital care, you need a plan that protects you from costly hospital bills. Be sure the plan you choose pays 100% of all hospital services—not just room and board.

Standard Option covers 100% of room and board plus 100% of other expensive hospital services—like operating rooms, intensive care units and X-rays—for as long as you need to be in the hospital.* You pay only a $100 deductible and for personal items like phone calls. That's protection you'll feel good about.

Comprehensive medical benefits. Your health care plan should help pay for a wide range of doctors' services, hospital outpatient care and many other health care expenses.

Standard Option pays 100% of the usual, customary and reasonable (UCR) charges, with no deductible, for outpatient treatment of accidental injury, well baby care up to age 6 and home hospice care up to $3000. Our new mail order prescription drug program also has no deductible; you pay only $5 for each prescription—Standard Option pays the rest.

For most of your other medical services, Standard Option pays 75% UCR after the deductible.

And you always have the freedom to choose your own physicians and hospitals, so you have maximum control over the quality of your health care.

Improved dental benefits. Regular, preventive dental care is the key to keeping your teeth and gums healthy. That's why Standard Option helps you pay for both preventive and routine dental care according to a fee schedule, with no yearly maximum and no deductible. And because it's so important to establish good dental practices early in life, Standard Option now pays an even larger portion of the bill for children up to age 13.

Sign up today. Now that you know the facts, it's easy to see why your family deserves Blue Cross and Blue Shield Standard Option—the health care plan that protects more federal employees than any other. Sign up today. Then rest easy, knowing that Standard Option is the health care plan you've been looking for.

If you need more information before signing up, call our Open Season Hot Line. Our representatives will be happy to discuss your specific needs. They're on duty 24 hours a day from October 20 to December 31. Call now.

Federal Employees...call now**

1-800-554-6800

Ask for Operator 200

Blue Cross
Blue Shield

CARRY THE CARING CARD.®

HOSPITALIZATION *LIFE* *ANNUITIES* *HEALTH & ACCIDENT*

Equitable Life and Casualty
INSURANCE COMPANY

LEGAL RESERVE CAPITAL STOCK

Area Code 801-521-2500
348 East South Temple

P.O. Box 2460
Salt Lake City, Utah 84110

March 1984

Dear Policyowner:

We at Equitable Life and Casualty Insurance Company wish to extend our appreciation and thanks to our Policyowners for your trust and confidence in allowing us to help you with your insurance needs. We encourage you to contact your local agent or the Home Office at any time you have questions regarding your policy, need assistance, or require additional life or hospitalization insurance.

For the past 4½ years, we have made available to our policyowners a method by which they can purchase prescription and non-prescription items at tremendous savings. As this service has been wholeheartedly endorsed by countless policyowners and has been extensively used, we are happy to again advise all of our policyowners, both old and new, that this service is being extended, and we encourage all of you to read the information that follows:

We are enclosing a new catalog price list which has been prepared exclusively for Equitable policyowners. In order to use this service and realize the savings offered, you may fill out an order form (be sure to include your Equitable policy number) and send it along with your doctor's prescription, directly to Pharmaceutical Services, 127 West Markey Road, Belton, Missouri, 64102. Your prescription will be filled within 12 hours and returned to you by first-class mail. Send no money with your order (a statement will be enclosed with your prescription). Please notice that some of the items are shaded; these items indicate generic drug names. By using the generic names rather than the brand named drug, the cost to you may be reduced by as much as 50%. Discuss the use of generic prescriptions with your doctor and show him the price list the next time a prescription is necessary. If your doctor does not use the generic names, you will still realize tremendous savings on brand names through this service.

You will not only save substantial money on your prescriptions, but you may save additional sales tax (depending on the state in which you reside, as Missourians pay sales tax only on non-prescription items). As an additional benefit, we have enclosed a special Gift Certificate for you, our special policyholder.

We sincerely hope that you and your family will utilize this service which we have arranged exclusively for our policyowners. If you have any questions on this service, please contact Lana Edmund, our Public Relations Representative here at the Home Office.

We again thank you for being a policyowner of Equitable Life and Casualty Insurance Company and sincerely hope that this Pharmaceutical service will be of assistance to you and your family.

Very truly yours,

Lewis R. Rich

Lewis R. Rich,
President

"Your Insurance should be Equitable"

drugs through the mail?

Absolutely! The Walgreen Company has been filling prescriptions since 1901 and operates drugstores in 30 states and Puerto Rico. So when you order by mail, you can be sure that every prescription will be screened and filled by a registered pharmacist for accuracy in quantity and potency.

How are orders handled?

When you order by mail, your prescription is reviewed, checked against your Registration Form, dispensed and verified by a registered pharmacist before it is mailed to you.

Now you have Alliance's Prescription Drug Program!

For further information, contact:

National Alliance of Postal and Federal Workers
51 Monroe Street, Rockville, MD 20850

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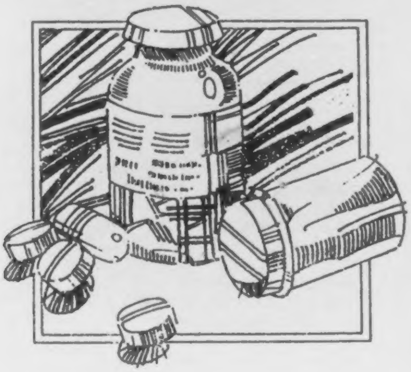
People you can count on...

Mutual of Omaha Insurance Company

Introducing Your New

ALLIANCE
HEALTH BENEFIT PLAN
MAIL-ORDER
prescription
DRUG PROGRAM



The plan that delivers to your door!

...Order by mail

...Saves time and money

...Convenient

Glen L. Barton
529 20 9325

Walgreens

WHAT IS THE DIFFERENCE BETWEEN GENERIC AND BRAND NAME DRUGS?

The generic name of a drug is its chemical name. The brand name is the trade name under which the drug is advertised and sold. By law, generic and brand name drugs must meet the same standards for safety, purity, strength and effectiveness. When you and your doctor authorize generic substitution, it permits the Pharmacy to dispense a generic drug. Unless your physician indicates otherwise, National will dispense a generic equivalent when available and permissable under the law. This saves your plan money. So whenever possible, ask your doctor to prescribe generic drugs.

HELPFUL HINTS

Check your prescriptions before you leave your doctor's office to make sure that:

- The doctor's name is legible.
- The exact daily dosage is indicated.
- The exact strength is indicated.
- The exact quantity is indicated.
- The full first and last name of the patient is legible.

Although NATIONAL normally ships your prescription to you within 48 hours of receipt, please allow 14 days for delivery from the date you mail your prescription order. All orders are sent via First Class Mail or UPS, but allowing ample time will help you avoid the chance of running out of medication.

IF YOU NEED HELP OR HAVE ANY QUESTIONS

Contact National's Customer Service Department, Monday through Friday, from 9:00 A.M. to 5:00 P.M. pacific time.

TOLL FREE NUMBER: 1-800-628-8881

This program is serviced by:
National Rx Services, Inc., of Nevada
P.O. Box 18100, Las Vegas, Nevada 89114

A Subsidiary of MEDCO Containment Services, Inc.

Form #U97

Utah Local
Governments
Insurance Trust

Mail Service Prescription Drug Program

a convenient plan designed to save you money and time.

Please complete the following section for all eligible family members

Deseret Mutual

Name ____ Relationship Code ☐☐ Date of Birth ____ Sex ____

Name ____ Relationship Code ☐☐ Date of Birth ____ Sex ____

Name ____ Relationship Code ☐☐ Date of Birth ____ Sex ____

Name ____ Relationship Code ☐☐ Date of Birth ____ Sex ____

Name ____ Relationship Code ☐☐ Date of Birth ____ Sex ____

(If additional dependents, attach separate sheet)

NUMBER OF PRESCRIPTIONS ENCLOSED ____

PRESCRIPTIONS ARE FOR: ☐ EMPLOYEE ☐ SPOUSE ☐ SON ____ (NAME)

☐ DAUGHTER ____ (NAME) ☐ OTHER ____ (NAME)

NOTE: Deductible (as determined by your plan) ____ X number of prescriptions ____ = $ ____ (amount enclosed)

I CERTIFY THAT THE INFORMATION ON THIS FORM IS CORRECT, AND AUTHORIZE RELEASE OF ALL INFORMATION TO PLAN SPONSOR OR DESERET MUTUAL.

DATE ____ EMPLOYEE'S SIGNATURE ____

*Please make check or money order payable to Health Care Services, Inc.

HCS HEALTH CARE SERVICES

Q. WHAT IS THE DIFFERENCE BETWEEN GENERIC AND BRAND NAME DRUGS?

A. The generic name of a drug is its chemical name. The brand name is the name under which the drug is advertised. By law, generic and brand name drugs meet the same standards for safety, purity, strength and effectiveness. When your doctor prescribes generically, or authorizes the generic substitution, it permits the Pharmacy to dispense a generic drug. This saves both you and your Plan money. So whenever possible, ask your doctor to prescribe generic drugs.

WHEN YOU ORDER BY MAIL, YOUR PRESCRIPTION IS:

1. Reviewed by a pharmacist;
2. Dispensed by a second pharmacist;
3. Inspected by a third pharmacist before it is mailed to you.

HOW TO ORDER HCS REFILLS . . .

With your original prescription medication, you will receive a notice showing the number of times it may be refilled. Simply enclose this notice with your maroon prescription card in the pre-addressed order envelope (which has also been provided) and mail. Be sure to include your maroon eligibility card with each order.

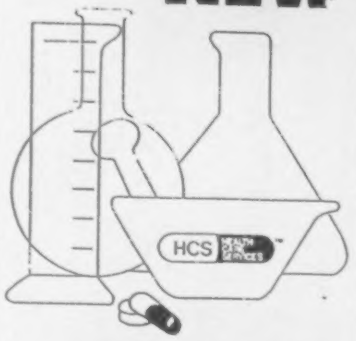
This program is serviced by:

HEALTH CARE SERVICES, INC.
100 W. City Line Avenue
P.O. Box 100
Bala-Cynwyd, PA 19004-3602

If you need help or have any questions, contact our Customer Service Department Monday through Friday, from 9 a.m. to 5 p.m. eastern time.

HCS Customer Service
TOLL FREE NUMBER
1-800-HEALTH-1 (Outside Pennsylvania)
1-800-222-7711 (In Pennsylvania)

NEW



MAIL-ORDER PRESCRIPTION DRUG PROGRAM

Saves you money every time you have a prescription filled.

Easy and convenient to use, this new program is ideal if you or a family member are taking medication on a regular basis.

[illegible] inside.

serviced by . . .

HCS HEALTH CARE SERVICES ™

Q. WHAT IS THE HCS PRESCRIPTION DRUG PROGRAM?

A. The HCS Prescription Drug Program is designed to provide medication to people who follow a regular drug therapy program. For the purpose of this plan, maintenance drugs are those prescribed for the control of a chronic disease or illness, or to alleviate the pain and discomfort associated with chronic disease or illness. Maintenance drugs must bear the federal legend "Caution: Federal Law prohibits dispensing without a prescription".

Q. WHAT IS COVERED?

A. Prescription medications as presently covered by your medical insurance.

Q. WHO IS ELIGIBLE?

A. Family members covered under your present medical coverage.

Q. IS IT SAFE TO ORDER PRESCRIPTION DRUGS THROUGH THE MAIL?

A. Yes, absolutely. Health Care Services (HCS) has been filling prescriptions through mail-order for many years. HCS guarantees that every prescription will be screened and filled by a registered pharmacist and be accurate in quantity and potency. HCS also guarantees that every health product shipped to you meets the highest pharmaceutical standards of quality, safety and effectiveness.

Q. WHAT ABOUT EMERGENCY SITUATIONS?

A. Obviously, there will be times when you need a prescription immediately. In these occasions, we recommend that you have your prescription fil   at a local pharmacy.

HOW TO USE THIS PROGRAM:

1. Ask your physician to prescribe needed medications for up to a complete 180-day supply. If you are presently taking medication, ask your doctor for a new prescription.
2. Complete the attached profile information form with your first order only. Be sure to answer all the questions, and make certain you include your Social Security Number on the form.
3. Send the completed profile form, your original prescriptions, and the appropriate deductible for each prescription to Health Care Services, using the enclosed reply envelope.

HCS will process your order and return your medications to you via UPS or First Class Mail, along with re-order instructions for future prescriptions and/or refills.

HELPFUL HINTS:

To ensure prompt processing of your order, check your prescriptions before you leave your doctor's office to make sure that:

- The doctor's name is legible.
- The exact daily dosage is indicated.
- The exact strength is indicated.
- The exact quantity is indicated.
- The full first and last name of the patient for whom the medication was prescribed is legible.

Discuss generic substitution with your doctor. When the doctor prescribes generically, or authorizes substitution of a generic drug, it helps to control the cost of your prescription drug plan.

Although HCS normally ships your medication to you within forty-eight (48) hours of receipt, please allow fourteen (14) days for delivery from the day you mail your prescription order. All orders from HCS are sent via First Class Mail or UPS, but allowing ample time will help you avoid the chance of runnir   out of medication.

DETACH HERE -- DETACH HERE

HCS HEALTH CARE SERVICES

PROFILE INFORMATION

101 W. City Line Avenue
P.O. Box 100
Bala-Cynwyd, PA 19004-3602

ase complete this form and return it to Health Care Services, Inc., in the enclosed pre-addressed envelope. Be sure to sign the form
...c enclose your prescription(s).

SOCIAL SECURITY NUMBER: ☐☐☐-☐☐-☐☐☐☐

GROUP NAME: DESERET MUTUAL

EMPLOYEE'S NAME: (Please Print) ______ First ______ MI ______ Last ______ SEX: M ☐ F ☐

ADDRESS: ______ Street ______ City ______ State ______ Zip ______

...ome Phone Number: ______ Work Phone Number: (Area Code) ______ Date of Birth: ______

Now you have the Postal Supervisors
Prescription Drug Program!

For further information, contact:

NATIONAL ASSOCIATION OF POSTAL SUPERVISORS
ORGANIZED SEPTEMBER 7, 1908

Postal Supervisors Health Benefit Plan
2094 Gaither Road
Rockville, MD 20850

Underwritten and sponsored by:

Mutual of Omaha
People you can count on...

Mutual of Omaha Insurance Company
Home Office: Omaha, Nebraska

MGC1274

INTRODUCING
YOUR NEW

Mail Order
PRESCRIPTION DRUG PROGRAM

From the Postal Supervisors
Health Benefit Plan

Think P.S.

**Postal Supervisors
Prescription Service**

Mutual of Omaha
People you can count on...

REGISTRATION FORM

ENROLLEE INFORMATION . . . *Please Print All Information Clearly*

FIRST NAME	MIDDLE INITIAL	LAST NAME	AREA CODE/TELEPHONE NUMBER

ADDRESS	CITY	STATE	ZIP CODE

BIRTH DATE MONTH DAY YEAR	SEX M F	GROUP NAME **Postal Supervisors Health Benefit Plan**	GROUP NUMBER G M G D D 9 0	ENROLLEE IDENTIFICATION NUMBER

ALLERGIES OR HEALTH CONDITIONS — PLEASE CHECK ( ) THOSE WHICH APPLY:

☐ 1 - PENICILLIN
☐ 2 - SULFA
☐ 3 - ASPIRIN
☐ 4 - TETRACYCLINE
☐ 50 - PREGNANCY
☐ 51 - DIABETES
☐ 53 - HEART CONDITION
☐ 54 - GLAUCOMA
☐ 55 - ULCERS
☐ 56 - THYROID CONDITION
☐ 57 - EPILEPSY
☐ - OTHER ____________ (PLEASE LIST)

Check type of prescription container you want for you and your family:
☐ Easy open cap
☐ Child-resistant cap

SIGNATURE ____________ DATE ____________

DEPENDENT INFORMATION
Please Print All Dependent Information Clearly...

RELATIONSHIP CODES
(AS RELATED TO THE HEAD OF HOUSEHOLD)

WI - Wife
HU - Husband
DA - Daughter
SO - Son
FC - Foster Child

ALLERGIES AND HEALTH CONDITIONS
Please check (✓) those which apply below:

01	FIRST NAME AND MIDDLE INITIAL	LAST NAME (IF DIFFERENT FROM ABOVE)	REL. CODE	SEX M F	BIRTH DATE MONTH DAY YEAR	☐ 1-PENICILLIN ☐ 2-SULFA ☐ 3-ASPIRIN ☐ 4-TETRACYCLINE ☐ 50-PREGNANCY ☐ 51-DIABETES ☐ 52-HIGH BLOOD PRESSURE ☐ 53-HEART CONDITION ☐ 54-GLAUCOMA ☐ 55-ULCERS ☐ 56-THYROID CONDITION ☐ 57-EPILEPSY ☐ -OTHER ____ (PLEASE LIST)
02	FIRST NAME AND MIDDLE INITIAL	LAST NAME (IF DIFFERENT FROM ABOVE)	REL. CODE	SEX M F	BIRTH DATE MONTH DAY YEAR	☐ 1-PENICILLIN ☐ 2-SULFA ☐ 3-ASPIRIN ☐ 4-TETRACYCLINE ☐ 50-PREGNANCY ☐ 51-DIABETES ☐ 52-HIGH BLOOD PRESSURE ☐ 53-HEART CONDITION ☐ 54-GLAUCOMA ☐ 55-ULCERS ☐ 56-THYROID CONDITION ☐ 57-EPILEPSY ☐ -OTHER ____ (PLEASE LIST)
03	FIRST NAME AND MIDDLE INITIAL	LAST NAME (IF DIFFERENT FROM ABOVE)	REL. CODE	SEX M F	BIRTH DATE MONTH DAY YEAR	☐ 1-PENICILLIN ☐ 2-SULFA ☐ 3-ASPIRIN ☐ 4-TETRACYCLINE ☐ 50-PREGNANCY ☐ 51-DIABETES ☐ 52-HIGH BLOOD PRESSURE ☐ 53-HEART CONDITION ☐ 54-GLAUCOMA ☐ 55-ULCERS ☐ 56-THYROID CONDITION ☐ 57-EPILEPSY ☐ -OTHER ____ (PLEASE LIST)

STATEMENT OF JAMES H. VINCENT
BEFORE THE SENATE GOVERNMENTAL AFFAIRS COMMITTEE
SUBCOMMITTEE ON GOVERNMENTAL EFFICIENCY, FEDERALISM, AND THE DISTRICT OF COLUMBIA

FEDERAL EMPLOYEES HEALTH CARE COVERAGE AND MAIL ORDER PRESCRIPTION DRUGS

AUGUST 5, 1987

Mr. Chairman, Members of the Subcommittee*:

I am James H. Vincent from Yuma, Colorado. I am a Past President of the National Association of Retail Druggists and serve as Chairman of the Mail Order Task Force.

Thank you for the opportunity to appear today before your subcommittee with NARD President Lonnie Hollingsworth and others to present our views and information on mail order drugs.

The Task Force was established in response to a growing number of complaints our members were receiving from consumers about mail order drugs. The hallmark of the independent pharmacy is personalized service including the maintenance of patient profiles, drug interaction and drug compliance consultation, home delivery and 24-hour emergency service. As assembly line mail order drug shipments began to expand, usually through the denial of freedom of choice for pharmacy services for employees under a corporate third party contract, our members became increasingly aware of consumer complaints about this faceless, depersonalized (usually out-of-state) method of distributing prescription drugs.

- Consumers requested emergency prescriptions when their mail order shipment was delayed or lost;

- Consumers inquired as to whether the drug they had been mailed was appropriate;

- Consumers sought advice about being mailed incorrect prescriptions;

- Consumers, especially the elderly, complained to our members that when the prescription drug did arrive, it was often in amounts later wasted because the physician had modified the treatment and changed the prescription;

- Consumers complained that they did not know how or to whom to report problems that they had experienced with mail order drugs.

---

* Jim Sasser (D-TN), Chairman
MAJORITY: (3-D) Senators Sasser, Carl Levin (MI), George Mitchell (ME)
MINORITY: (2-R) Senators John Heinz (PA), William S. Cohen (ME)

Additionally, we were receiving an increasing number of inquiries from public officials and the media about the nature and extent of prescriptions by mail order and about reports on the inherent reduction in the quality of health care as well as other actual abuses.

To meet these needs, the Task Force was established to assist in the effort to answer some of those questions. We also created a Clearinghouse to facilitate reports on these issues from our members. A brochure was developed to assist in answering patients' concerns (see Attachment 1) and questions.

In August of 1985, we published a one page form in the NARD Newsletter (see Attachment 2). Subsequently, we have received several hundred reports, most of which were provided on a confidential basis to protect the identity of the patients. At this point, I would like to share with the subcommittee a cross-section of the reports submitted to the Clearinghouse.

"My wife became readdicted because she got the drug from mail order after my hometown doctor and pharmacist had the situation under control. There is no question in my mind this uncontrolled source led to her further mental and physical deterioration. Only by a lot of work were the local pharmacists able to figure out where her supply was coming from and thus I could confront her and stop it...."

-- Lansing, Mich.

"I ordered a refill of Valium (from mail order)....A week later I got something else. I contacted my pharmacist....I read about the drug and found out it was an anticancer drug with many side effects."

-- Marine City, Mich.

"Eighteen bottles of insulin were left by UPS in an unused vehicle in hot weather (August) for an unknown period of time."

-- Des Moines, Iowa

"The patient's daughter presented this bottle to me and asked, 'Is this right?' Further dialogue revealed the patient had parathyroid surgery years ago, and as a result, needs large doses of calcium. The lady had been taking 650mg calcium lactate tabs, 3 tabs t.i.d. for years. When the mail order Rx arrived, the patient followed her same dosage regimen. However, the mail order Rx was filled with 325mg tabs. When the patient began to experience problems, she asked my advice. I explained the medical and Rx situation."

-- Cleveland, Miss.

"Because a patient's medication had not arrived and he was out, he asked me to call the MD for an oral Rx to hold him over until the mail in Rx arrived. He showed me his mail in Rx bottle for Isosorbide Dinitrate 20mg sig: Q.I.D. I called the MD and requested the above. MD remarked he had written for Isosorbide Dinitrate 40mg SA. Apparently the mail order pharmacy had improperly substituted without MD approval."

-- Massena, NY

"This prescription was written for Reglan tablets, one tablet twice daily, 1/2 hour before supper. The dispensed medication is Regroton. Mr. Meadows called me to inquire if it was the same as Reglan since he had been told the mail order company would substitute when possible. I explained the differences to Mr. Meadows, who by the way suffers no B/P problems, and gave him #100 Reglan tablets to replace this prescription."

-- Atlanta, Ga.

"....Recently, a patient brought in his medications....and he had in his possession thousands of each of his antihypertensive medications....filled up one-half of a grocery bag....All I know in this instance is that an elderly man living in Tennessee obtained through mail order prescription from New Jersey multiple thousands of tablets. This most definitely is a health hazard to dispense in such large quantities...."

-- Sweetwater, Tenn.

"Received generic phenobarbital 60mg made by Lilly on several occasions, but the last prescription filled was twice as large a tablet and had different markings. Had to take the Rx to my local pharmacy and ask my pharmacist for assistance. He tried to call my mail-order pharmacy to ask if the prescription was correct, as he did not recognize the pills, and was told they do not take collect calls under any circumstance, so finally he found out that my pills were correct by calling a local hospital's drug information center, but I am very unhappy with the service of the mail-order pharmacy. Especially annoying is switching generics and giving me no notice of the change, or telling the manufacturer on the label."

-- Davison, Mich.

"My insurance company insisted that I use generic drugs, and it seemed that every time I got my medicine, it was a different color. I had to wait till I called to make sure it was O.K. or return it...."

-- Huntville, Mo.

"....A prescription for Corgard 80mg was filled with Calan 80mg. An investigation was conducted and it was determined that an error had been made primarily because the prescription bottles were stored in close proximity...."

-- Warminster, Penn.

"....A mail order customer who was sent the wrong dose of morphine -- 11mg instead of 400. 'It's really frightening,' says....'This is a serious problem."

-- Ft. Lauderdale, Fla.

"The case involved an 86 year-old man who was on a prescription for Procardia for a mild heart attack which occurred in approximately January, 1984. He had the prescription filled through the AARP Pharmacy. The prescription was dispensed in plastic bottles approximately three inches high and I do not recall the number of capsules in each.

On the first refill, the bottle contained Feldene and the patient continued to take Feldene at the rate prescribed for Procardia. At that rate, the patient was taking Feldene at four times the maximum recommended therapeutic dosage. The patient developed a gastric ulcer as a result of this overdose and was hospitalized. While hospitalized, he had recurring heart problems and died of a heart attack.

The treating physicians were of the opinion that the trauma of the Feldene overdose and the deprivation of Procardia significantly raised the probability of a repeat heart attack and were further of the opinion that these factors were therefore a cause, though not the sole cause, of the fatal heart attack. Because of the client's age and pre-existing poor health, the case was settled for approximately $75,000.00 on a structured basis with all settlement proceeds paid to the widow. The decedent was childless."

-- White Stone, Va.

"Mail order is starting to take its toll on my customers. Here are a couple of situations that happened at my pharmacy.

I was talking about blood pressures at my store one day when a man came in experiencing chest pain. His blood pressure was 220/130. I asked him if he took blood pressure medicine. His answer was that he mails off for prescriptions, and the last time he mailed out for four prescriptions and received only three back. His blood pressure medicine was missing, so he called the mail order company on their toll-free number but did not get any response. He tried for several days and finally decided that they must have worked it out with his physician and had taken him off of that medicine. That mistaken assumption and error in mail order dispensing could have killed him.

Another instance was when a lady came in with a prescription for high blood pressure medicine. Her mail order company indicated that it was temporarily out of her medicine but would send it later. She had no medicine during this waiting period. Thinking that her medicine would arrive any day, she continued without medication for high blood pressure. Finally two weeks later and after many calls to her mail order company with no luck, she finally went to the doctor; thus, costing her another office visit and her local pharmacy drug bill with no insurance coverage.

Mail order has shown me that it is a gamble with people's health, and is a totally irresponsible and unprofessional way to dispense health care. Next there will be mail order prescribing. The only people benefitting from mail order are the insurance companies, mail order companies, and U.S. Postal Service. Our health system is thrown to the wind."
-- Grandy, N.C.

You have asked our views about the safety standards utilized by drug mail order houses. Frankly, we have no insider information about this subject, although it is my understanding that you will hear from others who do. There are many consequences, however, when the personal, face-to-face relationship with the pharmacist is eliminated from the prescription drug equation. In our view, the quality is inherently inferior.

The fact that these multistate mail order houses operate in a "Twilight Zone" of regulation or basically are unregulated could be a factor that would lead to less sensitivity about compliance with safety and soundness standards.

Certainly the nature of the delivery and inherent logistical problems make it difficult to correct an error. When the patient has no personal relationship with the pharmacist, and when the pharmacist has no personal relationship with the physician, and when the company that delivered the incorrect prescription is hundreds or thousands of miles away, even simple mistakes or misunderstandings can become complicated.

Regarding independent pharmacists, we are required by law to remove expired drugs from our inventory. State Pharmacy Board inspectors audit for such drugs. Regarding drug interactions as I mentioned, personalized service is the hallmark of the independent pharmacist and consultation about interaction and monitoring is frequent.

Again, the importance of personal interaction cannot be understated. FDA Commissioner Frank Young, M.D., at the recent annual meeting of the National Council on Patient Information and Education (NCPIE), emphatically made this point, "If the pharmacist isn't asking all the time, 'Are you following the regimen?' we're failing....Diagnosis left alone without treatment that's monitored and looked at for its curative effect and the lack of adverse reactions is no medicine at all. You may as well be hollering in the wind." Young stressed the importance of face-to-face communication, saying that "studies have shown that personal interaction has the greatest effect on imparting information to the patient."

The bottom line for the consumer is that they relinquish this essential professional service when they are forced to obtain mail order drugs, as is the case under the Blue Cross Blue Shield plan for federal employees and retirees.

ATTACHMENT 1

Mail order prescription drugs are NO bargain

National Association of Retail Druggists
205 Daingerfield Road
Alexandria, Virginia 22314
(703) 683-8200

R
Mail order drugs

A message from your independent pharmacist. . .concerned about your health

ATTACHMENT 2

Incident Report

This form has been prepared to assist you in reporting the problem you have experienced with a mail order prescription plan. It is important to document problems because exact medication and pharmacy care services are vital to your good health.

I am a worker/retiree/spouse of ______________________________
(circle one) (Company Name)

I experienced the following problem with a mail order prescription plan. (Please write as plainly as possible. Please provide as much detail as possible; send any container, label or medicine sample if this will help better describe the problem.)

(use reverse side if necessary)

We appreciate your cooperation in documenting this problem you have experienced in obtaining prescriptions by mail order.

Name ______________________________

Address ______________________________

City ______________ State ________ Zip ________

Telephone Number ( ) ______________________________

Return this form to:
National Association of Retail Druggists
Mail Order Clearinghouse
205 Daingerfield Road
Alexandria, VA 22314

NARD OFFICERS
LONNIE F. HOLLINGSWORTH, P.D., PRESIDENT
6119 - 34th STREET, LUBBOCK, TX 79410
D. J. WILLIAMS, P.D., PRESIDENT-ELECT
611 SECOND STREET, WEBSTER CITY, IA 50595
DONALD L. MOORE, P.D., FIRST VICE PRESIDENT
610 WEST MARKLAND AVE., KOKOMO, IN 46901
GENE GRAVES, P.D., SECOND VICE PRESIDENT
49 BENT TREE, LITTLE ROCK, AR 72212
KENNETH B. EPLEY, P.D., THIRD VICE PRESIDENT
1130 COMMERCIAL STREET, S.E., SALEM, OR 97302
DENNIS L. LUDWIG, P.D., FOURTH VICE PRESIDENT
4790 BASELINE ROAD, BOULDER, CO 80303
W. WHITAKER MOOSE, P.D., FIFTH VICE PRESIDENT
P.O. BOX 67, MT. PLEASANT, NC 28124
JOHN H. VANDEL, P.D., SECRETARY-TREASURER
2041 MAIN STREET, TORRINGTON, WY 82240

NARD EXECUTIVE COMMITTEE
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JOSEPH A. MOSSO, P.D.
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26 STAGE COACH LANE, NEWINGTON, CT 06111
CALVIN J. ANTHONY, P.D.
523 SOUTH WALNUT STREET, STILLWATER, OK 74074
LAWRENCE E. SCHREIBER, JR., P.D.
2608 NEWBRIDGE COURT, ST. LOUIS, MO 63129
WILLIAM L. SCHARRINGHAUSEN, P.D.
BOX 29-D, PARK RIDGE, IL 60068

CHARLES M. WEST, P.D.
EXECUTIVE VICE PRESIDENT

THE NATIONAL ASSOCIATION OF RETAIL DRUGGISTS

205 DAINGERFIELD ROAD, ALEXANDRIA, VA 22314
(703) 683-8200

September 2, 1987

Ms. Denise A. Botsaris
Chief Clerk
Subcommittee on Government
Efficiency, Federalism, and the
District of Columbia
Committee on Governmental Affairs
United States Senate
Washington, DC 20510

Dear Ms. Botsaris:

The purpose of this correspondence is to respond to questions submitted by you on behalf of Senator Heinz to Mr. Jim Vincent, regarding the August 5-6 hearing on the Safety and Soundness of the Mail Order Drug Industry.

Question:

Please clarify your testimony of August 5, 1987: "Regarding independent pharmacists, we are required by law to remove an expired drug from our inventory. State Pharmacy Board inspectors audit for such drugs." Are you testifying that mail service pharmacies are not considered independent pharmacies and thus not subject to removal of expired drugs from their inventories and/or are not subject to such State Pharmacy Board audits?

Answer:

No. See following.

Question:

What kind of redress provisions would you recommend be instituted for recipients of mail service drugs if indeed they do not have opportunities for redress comparable to those held and deemed adequate by recipients of retail pharmacy drugs?

that is available to the patient, which in our view, is essential to the provision of quality health care. Eliminate from the health care equation the personal relationship between the physician and pharmacist, and between the pharmacist and patient, and you diminish the ability of these professions to provide full service to the patient. Elimination of these interpersonal relationships are hardly compensated for by telephone calls or correspondence. Would you, for example, be equally satisfied in dealing by the mail or phone with a family lawyer or physician whom you had never met? Certainly the testimony provided to the subcommittee on August 5 regarding the practice of pharmacy via the mail for federal employees and retirees demonstrates a myriad of possible developments once the interpersonal linkage between the health care professionals and the patient is severed. According to the testimony, for instance, those practicing pharmacy through the mail were totally prohibited from any interactions with the patients, and physicians for that matter, including contact by telephone or letter with the physicians and patients. We are unaware of any study that compares the consequences of such practices when compared with the experience that the more typical patient/consumer has when he or she is guaranteed interpersonal access to the physician and pharmacist.

The FDA Commissioner, Dr. Frank Young, has stressed the importance of these relationships and face-to-face communication saying that, as mentioned in the testimony of NARD's Mail Order Task Force Chairman, Mr. James Vincent, "studies have shown that personal interaction has the greatest effect on imparting information to the patient." We have contacted Dr. Young regarding your interest in an effort to obtain studies on the importance of these traditional common sense practices.

It is essential, in our view, that with mail order drugs, consumers be informed that they are not receiving the benefits of full pharmacy services. In instances like the Blue Cross Blue Shield/Medco federal program, where employees and retirees are forced to utilize mail order, or in cases where they choose without coersion to obtain prescription drugs through the mail, at a minimum, they should be assured to the extent possible, that the health care and law enforcement officials of their states have an equal opportunity to protect them. After all, this is not a problem of the regulation of widgets moving in commerce, but the practice of pharmacy, albeit inferior in our view, across state borders.

Question by Senator Heinz:

Please illustrate the regulations, that retail pharmacists are subject to under respective state pharmacy boards which mail service pharmacists are not subject to. What suggestions might you have to ensure, in your opinion, more effective regulation of mail service pharmacies?

Answer:

Rather than isolating particular requirements of states, we have enclosed a copy of the National Association of Boards of Pharmacy (NABP) Survey of Pharmacy Law 1986-87 that contains most state regulations. The problem at hand is one of jurisdiction and in turn, minimal at best, law enforcement regarding the practice of pharmacy vis-a-vis the post office.

Question by Senator Mitchell:

Your written statement (p. 4) says, "recent studies indicate that, especially with the elderly, costs [of mail order drugs] exceed those of pharmacies." Please provide a copy of any studies which support that contention.

Answer:

Enclosed is the principle study providing the documentation you requested indicating the higher costs of mail order, especially for the elderly: "Actuarial Study of Mail Order Drug Option Experience", August 1, 1986, authored by Sieben & Associates, Inc., for Pharmaceutical Card System, Inc. As you will note in this study, one of the reasons it costs more is referred to as "wastage". Some efforts have been made to reduce "wastage" principally, by limiting the prescription to a 30-day supply.

An additional factor on the horizon regarding higher costs of mail order drugs is addressed in the enclosed article in Barron's magazine, April 13, 1987, p. 13, entitled "Rx for Hot Stocks, Why Porex and Medco Sell at Eye-Popping P/Es". This report documents through entepreneurs involved with mail order drugs that they are in the "lost leader" phase of their marketing, that in pitching mail order drugs to prospective corporations, unions, or government clients, they are (p. 86) "virtually giving the drugs away to build big volume in a low-margin, high volume business." Therefore, it can be reasonably concluded that in the future, as the drug product costs are reflected, the overall cost of mail order drugs will exceed traditional pharmacy by even a greater margin.

Another relevant factor in the cost of drug products utilized by these mail order outfits was addressed in the July 27, 1987, Forbes Magazine article entitled, "What's not in the prospectus", p. 61. This article dealt with one of the major for-profit mail order corporations and very serious questions as to whether the corporation was utilizing the illegally diverted drugs which can be acquired on the average and usually from nonprofit entities such as hospitals at 1/10 of the cost to our members. The article is enclosed and interestingly enough concludes with the following (p. 62), "'Prescriptions by mail? What a wonderful way to get rid of diverted drugs.' Caveat emptor."

You'll be interested to know, regarding our major nonprofit competitor, AARP, in spite of all their various subsidies, our members are generally price competitive with AARP. A typical tactic with AARP, however, is to pitch to tneir customers the difference between branded and generic drugs, portraying the private sector pharmacies as if they provide only branded drugs and claiming that savings, via generic drugs, are only obtainable for prescription drugs through the mail from AARP.

Question by Senator Mitchell:

Please provide any documentation which would indicate that the error rates of mail order pharmaceutical firms, in terms of errors that are actually received by patients, is greater than the error rates of retail pharmacists.

Answer:

We are unaware of any available data in response to the question. You would think OPM would have had such concerns in mind before they forced federal employees and retirees to obtain prescription drugs through the mail. It appears, however, that OPM and others view the providing of prescription drugs to patients solely as a cash transaction, with little or no concern regarding the question you have raised.

In view of the fact that typically the state where a mail order outfit is located, as well as the states in which they are practicing pharmacy, for a variety of reasons, do not monitor such practices, it presently would be very difficult to conduct an appropriate study to develop information in response to your question. Unfortunately, most consumers are not as sophisticated in the ways of government regulations, rules and statutes as was Mrs. Winifred Owens who presented testimony to the subcommittee. When she contacted the Virginia Board of Pharmacy and was told basically, "It's not my job", she persisted and eventually interacted with officials in Florida and even her own Congressman. If a citizen/patient has a problem with a pharmacist subjected to the laws and regulations of that patient's state, they know to complain to appropriate officials in that state and they know such officials will take appropriate actions. In the instance of mail order drugs, however, it is very unlikely that the typical individual who experiences any of a myriad of problems cited to the subcommittee would have the sophistication to know where and how to file a complaint.

Therefore, even basic information, namely the filing of a complaint, would typically not be available. This predictable result is even further enhanced by the fact that most mail order outfits highlight the utilization of an 800 number for any complaints. Combine this common practice with the fact that these businesses basically operate in an unregulated environment, and it becomes even a greater challenge to conduct such a study.

Regarding the conduct highlighted by witnesses before the subcommittee, however, we do suggest that the subcommittee obtain from the corporation(s) involved, all consumer complaints filed via the 800 number. Additionally, it would be interesting to determine whether or not the complaints of these out-of-state patients were brought to the attention of the Board of Pharmacy of the state in which the corporation is located. Further, we certainly would support such a study if the factors including those we have identified which presently inhibit conducting a sound study were controlled.

Once again, we appreciate the opportunity to participate in the Subcommittee's investigation and look forward to working to assist the Subcommittee and its staff in fashioning the appropriate legislative response.

With warm regards,

John M Rector

John M. Rector, Esq.
General Counsel & Vice President
Government Affairs

Enclosures
JMR/mbs

MEDCO CONTAINMENT SERVICES, Inc.
491 Edward H. Ross Drive, Elmwood Park, NJ 07407
(201) 794-1000

Testimony of Mr. Martin J. Wygod
Chairman of the Board and
Chief Executive Officer of
Medco Containment Services, Inc.

August 5, 1987

Hearings before
the Senate Subcommittee on Government Efficiency,
Federalism and the District of Columbia,
Committee on Governmental Affairs, United States Senate.

Mr. Chairman, I am Martin J. Wygod, Chairman of the Board and Chief Executive Officer of Medco Containment Services, Inc. Medco has affiliates and subsidiaries with major facilities in New Jersey, Ohio, New York, California, Nevada, and Florida and is now the largest public provider of mail service prescription drug programs in the nation.

This statement is intended to provide background about Medco's mail service prescription drug program and to make available to the Subcommittee information material to an objective evaluation of the safety and soundness of mail service pharmacy operations currently promoted under federal health insurance programs authorized by the Office of Personnel Management.

At the outset, it is important to note that mail service pharmacy is not a new, or even novel, development in the practice of pharmacy. The Veteran's Administration initiated a program as early as 1946 and the American Association of Retired Persons (through the AARP Pharmacy Service) has offered a similar program to its members since the early 1960's. The rapid growth of mail service pharmacy and participation by others has been due to a variety of factors, not the least of which is consumer demand for a prescription drug system that offers cost savings, convenience, and safety. Mail service sales of prescription drugs has grown 50% per year since 1981, from less than $100 million in 1981 to $750 million in 1986. It is estimated that mail service sales shall increase 30% per year through 1991, reaching $2.8 billion or 10% of the total U.S. prescription drug market.

The dynamics of such growth speaks well of the concept and is based, in substantial part, not only upon the well-recognized cost savings but also the proven safety and soundness which underlies this type of pharmacy practice. Safety is a necessary component of any consumer business and is critical in a health care service. I am confident our safety record is as good as that of any industry in the U.S. It is important that our consumers be satisfied with our products and service and we believe our industry has been successful in this regard.

In fact, Mr. Chairman, the University of Tennessee, Gollege of Pharmacy, Center for Pharmacy Management and Research, conducted an Evaluation of Consumer Opinions of Prescription Drug Services from Community and Mail Order Pharmacies in 1986 and the results help demonstrate our point. The study concluded that "the rating for mail order services was slightly better than the rating for community pharmacy services."

Medco's primary focus of operations is as a provider of mail service prescription drug programs to medical benefit plans funded by corporations, unions, associations, and governments. Our wide client base stands as a testament to the safety of our programs. The following quality control steps and cost containment measures help ensure our safety record remains excellent:

- Processing prescriptions the day they are received.
- Reviewing every prescription for completeness and clarity.
- Developing and maintaining patient profiles for participants.
- Checking all new and refill prescriptions to verify eligibility, to monitor and control refill activity, to prevent duplication of medication, and to screen for possible adverse drug interactions.
- Contacting the physician concerning questions about the prescriptions.
- Dispensing only quality brand-name and generic medication according to the prescriber's instructions and in compliance with federal regulations and all applicable state laws in the state in which the facility is located.
- Dispensing generic drugs for brand-name drugs where permitted unless the prescriber prohibits the substitution.
- Dispensing only generic drugs that are bioequivalent and therapeutically equivalent and checked for continuity of product as to size, shape, color, taste, viscosity and for manufacturing source.
- Maintaining a strict drug inventory control so that different potencies of the same drug or look-alike and sound-alike drugs are not stored next to each other, and to ensure that drug stock is rotated on a controlled basis.
- Mailing a drug information leaflet with prescriptions for the majority of prescribed drugs when dispensed as a new prescription.
- Sealing the protective shock-and-tamper resistant packages containing the prescription medications before sending them to the mail station. This is done by the dispensing pharmacist and the packages do not indicate that drugs are enclosed.
- Delivering prescription packages to assure that the patient receives the medication in seven to ten days from the date the request was mailed.

- Continuing review of the dispensing process and the introduction of new technology to the dispensing operations to ensure that the Company maintains the highest standards of the pharmacy profession.

Traditionally, the actual cost savings of the Company's mail service prescription drug programs range between 20% to 40% over the cost of drugs purchased and reimbursed under traditional plans. The savings are achieved through adherence to a number of fiscal indicia:

- A rate of generic substitution more than twice the national retail average for maintenance medications, coupled with highly competitive generic drug costs. The Company's generic drug prices are up to 75% less than the price of the brand name product they are replacing, and are lower cost than most other competitive generic drug products. These two factors result in significant cost reductions.
- A highly competitive price structure based on wholesale, not retail, drug costs. Effective drug purchasing management practices emphasize the finest quality products purchased at maximum discounts.
- A low, fixed charge to fill each prescription, compared to the retail practice of varying the ingredient cost mark-up. Continuing implementation of advanced computer and dispensing operations result in productivity increases which can reduce the cost of dispensing a prescription.
- A comprehensive communications and education program which maximizes consumer awareness of drug costs, the availability of generic drugs, and the benefits of mail service.

As a result, the program sponsor and the patient are benefited in a number of significant ways. By way of example, the sponsor has a cost effective program distinguished by reduced administrative costs, the control of drug misuse/abuse, concurrent patient utilization review, predispensing drug interaction/

drug to medical condition review, and, predispensing eligibility verification. On the other hand, the patient participates in a program distinguished by less out-of-pocket expenses, no claim forms to file, no waiting period for reimbursement, convenience of home delivery, security of a longer-day supply, drug explanation leaflets, and, a toll free service number with access to a registered pharmacist.

Mr. Chairman, I have attached an appendix which answers in detail each question in your letter of July 29, 1987, inviting us to testify at today's hearing. We would be pleased to supplement this information with any additional information you or other members of the subcommittee request.

In conclusion, we believe mail service pharmacy is another example of American innovation. It is an innovation which improves the quality of health care services while reducing the cost of medical care. It is a positive change and we encourage you to help nurture this growing health care service.

I would be pleased to answer any questions.

Appendix: Response to Subcommittee Inquiries

1. **What is the volume of your mail order prescription business?**

During the six months ended June 30, 1987, the Company, through its subsidiaries, dispensed approximately 5.1 million prescriptions. During the month of July 1987, approximately 825,000 prescriptions were dispensed.

2. **How many prescriptions do you fill daily per plant?**

Set forth opposite the name of each of our pharmacies is its location and the average number of prescriptions dispensed during the month of July 1987.

Daily

Name of Pharmacy	Location	**Average Number of Prescriptions Dispensed During July 1987**
National Rx Services, Inc. (a California corporation)	Los Angeles, California	160
National Rx Services, Inc. (a California corporation)	San Diego, California	280
National Pharmacies, Inc. (a New Jersey corporation)	Elmwood Park, New Jersey	10,500
NRx Services, Inc. (a New York corporation)	Albany, New York	1,500
National Rx Services, Inc. (an Ohio corporation)	Columbus, Ohio	6,000
National Rx Services No. 2, Inc. (an Ohio corporation)	Columbus, Ohio	10,000
National Rx Services, Inc. of Nevada (a Nevada corporation)	Las Vegas, Nevada	4,000
National Rx Services, Inc. (a Florida corporation)	Tampa, Florida	8,500
TOTAL		40,940
Per registered pharmacist per day[1/]		145

3. How many registered pharmacists do you employ on a daily basis to fill mail order prescriptions?

As of July 31, 1987, the Company employed 282 registered pharmacists (which includes 34 registered pharmacists in supervisory and managerial capacities).

4. On average, how many pharmacy technicians assist your pharmacists in dispensing your mail order prescriptions?

Each of the Company's pharmacies complies with the laws and regulations of the state in which it is located regarding use of pharmacy technicians. The following table sets forth by location the number of technicians who assist pharmacists in dispensing mail service prescriptions at July 31, 1987.

Name and Location of Pharmacy	**Number of Registered Pharmacists**	**Number of Assisting Technicians**
National Rx Services, Inc., (Los Angeles, California)	2	0
National Rx Services, Inc., (San Diego, California)	3	0
National Pharmacies, Inc. (Elmwood Park, New Jersey)	52	53
NRx Services, Inc. (Albany, New York)	13	0
National Rx Services, Inc., (Columbus, Ohio)	32	32
National Rx Services No. 2, Inc. (Columbus, Ohio)	46	50
National Rx Services, Inc. of Nevada (Las Vegas, Nevada)	36	0

1/ Based upon the average number of registered pharmacists employed on a daily basis to dispense prescriptions.

National Rx Services, Inc., (Tampa, Florida)	98	9
TOTAL	282	143

5. Does your firm employ a "quota" system with regard to the number of prescriptions that must be filled by pharmacists and pharmacist technicians? If so, describe the nature of this quota system (hourly, daily, or weekly).

The word "quota" implies a hard and fast rule that all those failing to meet some fixed number will be sanctioned or discharged. The Company does not employ any such practice or procedure.

Instead, the Company has established certain goals that it would like to see achieved by all pharmacists and assisting technicians employed at our New Jersey and Ohio facilities. The manner in which these figures are applied, as the Company will detail, plainly dispels any notion of a quota. In addition, at our New York, Nevada, Florida, and California facilities, we do not even maintain productivity records by individuals, although general guidelines have been communicated to the pharmacists at those locations.

In computing these goals, the Company carefully drew upon its eighteen years of experience in the practice of pharmacy as well as a study prepared for it by independent consultants. On the basis of this knowledge, the Company determined the rate at which a pharmacist or an assisting technician, working at 100% efficiency, could perform these functions without in any way sacrificing quality. Then, as an added quality safeguard, the Company reduced these rates in half in order to arrive at the guidelines that we actually employ/ and which in practice have proven to be realistic.

Unlike with a quota, the Company does not rigidly or blindly enforce the goals. To the contrary, the Company views these figures as goals to be achieved by each individual pharmacist or assisting technician only to the extent consistent with his/her ability to achieve any rate that would require the pharmacist to sacrifice quality or his professional obligations. Thus, before a pharmacist is ever requested to achieve any optimum level, he or she is fully trained regarding the proper procedures for dispensing and checking prescriptions.

The Company's intent to establish goals rather than quotas is further evidenced by two pharmacists that it currently employs. These individuals, who have been with the Company for many years, and who continue to be extremely accurate pharmacists, have recently been unable, for physical reasons, to meet consistently the goals. Nonetheless, the Company has no intention of disciplining or taking any adverse action against employees such as these who make an effort to be productive while maintaining the highest standards of quality.

Moreover, our supervisors do not even speak with a pharmacist or an assisting technician regarding productivity unless his or her rates have been consistently below 80% of the goals for a period of several weeks. Even then, the nature of the discussion between the supervisor and the pharmacist or technician almost always takes the general form of a pep talk or informal counseling.

Of the Company's 425 pharmacists and technicians, only three have been formally disciplined regarding productivity during 1987. In all or most of these cases, the individual's failure to meet the goals resulted not from the individual's failure to work at a certain rate, but from his/her inefficient use of time. In fact, some of these individuals had met or far exceeded the goals, without sacrificing quality, for substantial periods prior to such action. Accordingly, these individuals were instructed to use their time more wisely by reducing the time expended on non-work related matters.

It should also be noted that we do not assign pharmacists for the entire day to functions for which the Company has assigned a goal. Instead, they are rotated through a variety of other tasks, including utilization review, doctor calls, screening, dispensing compounds and narcotics, and, from time to time, customer service.

Finally, the Company does maintain a bonus system for registered pharmacists in New Jersey and Ohio that is based upon these benchmarks. The bonus, however, does not simply reward those pharmacists who exceed the benchmark. It also serves as an overtime premium even for those pharmacists who do not exceed the benchmark.

The Company does not expect nor does it encourage pharmacists to achieve the bonus by exceeding the goals. Although the situation has never occurred, if the Company were to discover that any individual was sacrificing quality in order to achieve the bonus, we would immediately direct that individual to decrease his or her rate to a level where there was no adverse effect on quality. Experience, however, has shown us that the bonus system has no such adverse consequence. To the contrary, those pharmacists who have continually achieved the bonus by exceeding the goals are among the most extraordinarily competent pharmacists who have in no way sacrificed quality.

In summary, the Company's primary commitment is to quality. Only after this goal is achieved does the Company begin to concern itself with productivity.

6. In general what are the considerations of safety and soundness that you follow in dispensing mail order prescriptions? Specifically, what protections are taken to prevent the dispensing of wrong prescriptions?

Each of the Company's pharmacies is licensed by the state in which it is located and must comply with the regulations promulgated by that state's Board of Pharmacy. Accordingly, our pharmacies and pharmacists are subject to the same licensure requirements that apply to other retail pharmacies. The Company, however, has gone beyond the statutory and regulatory requirements. By implementing sophisticated dispensing processes, the Company operates at a higher level of safety than other retail pharmacies. We believe this is required since our clients include many fortune 500 companies, labor unions, retirement systems, and major insurance carriers who often scrutinize our dispensing procedures prior to installing our program.

The following outline of the Company's practices is offered in further response to the above inquiry. Since state laws may vary in certain respects, each pharmacy's operations may vary from the following in some instances in order to maintain compliance with such state law.

A. Initial Screening Process

(1) The first quality control check occurs during the screening operation. A registered pharmacist reviews each prescription received as to eligibility, availability of generics, accuracy, and clarity. In performing this function, the registered pharmacist uses the CRT located at the screening station to access directly the Company's computer files. In order to maintain accountability, each pharmacist in gaining access to the system must enter his or her personal I.D. code which is recorded on the permanent prescription file. A screening pharmacist performs the following tasks:

(a) The client plan master file is accessed on-line and the prescription is checked against it to ensure that the medication prescribed is covered under the client's plan definition.

(b) A generic drug file is accessed on-line to determine whether or not a generic drug is available pursuant to the applicable state law.

(c) The prescription is coded with a unique Drug Code number which contains a check digit to prevent error due to transposition of drug numbers. The unique Drug Code number ensures that the correct drug is entered into our computer file from which labels are printed.

(d) The prescription is revised for clarity by the registered pharmacist. If a prescription requires clarification, it is forwarded to the Professional Service area so that a registered pharmacist may contact the prescriber. Common reasons for contacting the prescriber are:

- any part of the prescription is illegible
- instructions are unusual or unclear
- additional information (such as dosage, strength, quantities, directions, etc.) is required
- all Schedule II drug prescriptions are verified with the prescribing physician

In New Jersey and Ohio, certain of the foregoing tasks, to the extent consistent with state law, are performed by assisting technicians.

(2) All prescriptions for Schedule II drugs are immediately separated from the remainder of a patient's order and delivered directly to a secured narcotics dispensing area.

B. Eligibility, Interaction, and Abuse Controls

After the initial screening has been completed, prescriptions are routed to the computer data entry area. The patient's prescription information and patient profile history questionnaire, if provided, is typed into the order entry system which incorporates extensive edits to verify eligibility, monitor and control refill activity, prevent a duplication of orders and screen for possible drug interactions. If an eligibility problem exists, the prescription is removed from the work flow and forwarded to the Customer Service Department. An Eligibility Representative telephones a person designated by the client to check eligibility. If the person involved is eligible, the prescription is processed; if not, the prescription order is returned to the patient with an explanation. In this way, eligible persons are never denied medication, while at the same time, the client is protected against unauthorized use of the program.

After the eligibility verification, each prescription is checked against the patient's profile (which includes all medications dispensed to him or her during approximately the past 18 months) using the Adverse Drug Interaction Program (described below) to ensure that all potential drug-to-drug interactions are flagged. Potential over-utilization situations, such as refills or duplicate prescriptions, are also flagged. In all instances of potential drug interaction or over-utilization, a hard copy Exception Profile is generated.

C. Utilization Review

Each Exception Profile is reviewed by a registered pharmacist and, if necessary, consults with the prescriber before the order is allowed to proceed further. Examples of situations involving Exception Profiles are:

- Refill orders received early are evaluated and if determined by the registered pharmacist to be premature are returned to the patient with appropriate information.

- Potential adverse drug reactions are evaluated by a registered pharmacist and discussed with the prescriber if appropriate.

In order to maintain accountability, the registered pharmacist initials each Exception Profile reviewed. These documents are then filed.

D. Dispensing

(1) The Company employs a unique system of checks in its dispensing process including this segregation of drugs with similar names or appearances to different areas of the pharmacy. This procedure significantly reduces any risk of human error by focusing the registered pharmacist's immediate attention on a limited number of drugs. The Company also uses its own proprietary computer system to assist in actual dispensing of medications. The prescriptions are routed to one of four dispensing areas as indicated by the unique computer assigned numerical identification code for each prescription. This allows the pharmacists to concentrate their efforts on the dispensing of the proper drugs as opposed to locating the medication within the pharmacy. The specific dispensing areas are:

(a) Automated Dispensing Area - Most Frequently Prescribed Drugs

The most frequently prescribed drugs are stored in automated counting cells (Baker Cells) which are also commonly used in the retail and hospital pharmacies. Each cell is calibrated to dispense only one specific medication. The automated counting equipment is operated by a registered pharmacist and is an accurate and efficient method for the counting of high-volume prescriptions. These drugs represent the majority of prescriptions filled.

(b) Dispensing Area - For Most Other Drugs

If the prescription order is for a less frequently prescribed drug, it is routed to a designated vertical carousel staffed by a registered pharmacist. These carousels are especially designed for the Company to assure error free dispensing.

(c) Compounding Areas - Prescriptions That Require Special Preparation

Prescriptions requiring special preparation, such as compounds, ointments, liquids, suppositories, etc. are prepared and dispensed by registered pharmacists.

(d) Controlled Substances

When orders containing more than one prescription include a Schedule II substance, the prescription for the Schedule II substance is segregated from the rest of the order, verified by phoning the prescribing physician, and forwarded to the secured narcotics dispensing area. This area is totally segregated from the remainder of the pharmacy by a system of locked cages. Only a designated registered pharmacist may access this area or dispense these drugs. These drugs are shipped only by United Parcel Service ("UPS") with receipted delivery and are limited to 30-day supplies or 120-dosage units, whichever is less.

Prescriptions containing Schedule III through Schedule V substances are not separated from the rest of an order, but they are filled last to avoid the drug from being routed through the pharmacy. These drugs are stored in a locked controlled area accessible only to designated registered pharmacists.

(2) In New Jersey and Ohio certain of the foregoing tasks to the extent consistent with state law are performed by assisting technicians. In such states where technicians assist in the process, the orders are routed to a registered pharmacist to check and verify each prescription order. The pharmacist compares the

computer-generated label to the actual medication dispensed and the original prescription. Each container is opened and the contents are inspected. When the pharmacist approves and releases the medication, he/she stamps his or her unique identification number on the prescription label, places the medication in a shipping package, and seals the package.

(3) Each prescription label includes the name, address and telephone number of the pharmacy, name of the pharmacist, name of the manufacturer, name and potency of drugs, quantity, directions for use as specified by the prescriber, and any other special instructions to the patient.

(4) For all controlled substances, the Company maintains an audit trail identifying each drug and potency including to whom it was dispensed and by whom prescribed.

(5) Pharmacists have immediate access to a current professional library.

E. Mailing

Most orders are packed and sealed by a registered pharmacist prior to entering the mailing area. All orders (except for Schedule II substances and Schedule III through Schedule V narcotics which are sent by UPS for receipted delivery) are routed to the mailing station for delivery by first class mail conforming to postal regulation. Orders are presorted and bagged by geographic location in order to speed the delivery process and are delivered to the postal facilities throughout the day. The packages are shock- and tamper-resistant and bear no markings that drugs are enclosed.

F. In-House Turnaround

Complete orders are normally processed within 24 to 48 hours of receipt. Orders requiring additional information will usually be processed within 48 to 72 hours. In either case, the plan participant will normally receive the medication within 6 to 10 days from the time the request was mailed.

G. Audit Trail

Each individual who handles the prescriptions is assigned a unique I.D. number. This number is stamped not only on the prescription label, but also to the Company's internal filing label which is affixed to the back of the original prescription, remains part of the permanent company records for five years. This provides a complete audit trail to ensure complete accuracy and accountability in the filling of each prescription.

H. Patient Communications

The majority of prescriptions dispensed include a drug information leaflet prepared by the United States Pharmacopeia Convention when available. These leaflets provide the patient with additional information such as possible side effects, drug precautionary statements, and the like.

The initial brochure and each reorder envelope lists a toll-free customer service representatives and registered pharmacists are available 12 hours per day for patient questions.

7. **What protections are taken to prevent the dispensing of outdated drugs?**

(a) The Company employs 75 persons in its inventory control area and maintains procedures which are comparable to those of any well run pharmacy inventory control system.

(b) The Company buys 98% of the brand name drugs dispensed from only two sources directly from the manufacturer of such drug or from Bergen Drug Company, a subsidiary of Bergen Brunswig Corp., the second largest wholesaler of prescription drugs in the nation with annual sales in excess of $3 billion. Purchases from Bergen Drug Co. are based on orders placed directly to the manufacturer on the Company's behalf. Deliveries are made by the manufacturer to Bergen's regional distribution centers where the product is held for delivery directly to the Company's pharmacies and not typically commingled with Bergen's other inventory.

The Company buys 98% of generic drugs dispensed from H.L. Moore Drug Company, a subsidiary of Moore Medical Corp., one of the largest generic drug distributors with annual sales in excess of $200 million. The balance of drugs purchased represents purchases from established local wholesalers in the event our primary source cannot supply such drugs on a timely basis. By limiting our purchases to nationally recognized suppliers, and concentrating its buying power, the Company believes it has been able to command an extraordinary level of diligence from its suppliers. This allows the Company to maintain an unparalleled consistency of product and supply.

(c) The Company does not accept delivery of products which are stamped with an expiration date less than 12 months from the date of receipt. The expiration date is checked by inventory control personnel who immediately contact the vendor for replacement of any short dated product. If the maximum dating available from a manufacturer is less than 12 months i.e., Leukeran (Borroughs Welcome), a quantity of inventory of this product would be maintained only for dispensing in the near future.

(d) The Company does not dispense any product which is stamped with an expiration date within six months. Monthly, the Chief Pharmacist and Inventory Control Manager conduct a complete inspection of the pharmacy to identify and remove products with an expiration date within six months. The product is isolated and stored in a separate area in the pharmacy until vendor return authorization is allowed.

(e) Physical counts of all product inventory are conducted at least semi-annually at each pharmacy. These counts are conducted by independent count service employees and observed by corporate inventory control personnel. Expiration dates of products are checked in the preparation of, and during, these counts.

(f) A log is maintained for all automatic dispensing cell showing each date filed and the lot number and expiration date of each original container from which the equipment was filled. Accordingly, at any given time, it is possible to determine the lot number and expiration date of the drugs contained in all such equipment.

(g) All products are stored in dispensing or inventory control areas of the pharmacy with access restricted to authorized personnel. Security Department staff are permanently stationed in the receiving area to limit access to the pharmacy. Cameras are located in the dispensing and product storage areas which are monitored by security personnel. Controlled substances are stored and dispensed in physically secured areas with access restricted to designated pharmacists. Products that require special handling such as insulin are stored in temperature controlled refrigeration units located in the dispensing and inventory control areas.

(h) Schedule II narcotics are ordered using the standard DEA Form # 222 that is filed with the appropriate governmental agencies. Copies of vendor invoices for all controlled drugs are kept on file under supervision of the chief pharmacist. Statements of monthly purchases of all controlled drugs are obtained from each supplier and kept on file under the supervision of the chief pharmacist. All Schedule II substances are segregated upon receipt and stored in a separate secured area. The Schedule II drug dispensing area is in an area of immediate proximity to the facility's security station. Independent perpetual inventories are kept of all Schedule II drugs. Physical inventories are taken monthly of all Schedule II drugs and compared to perpetual records.

All Scheduled III through Schedule IV are also are segregated upon receipt and stored in a separate and secure area for which access is restricted to designated registered pharmacists. Independent perpetual inventory records are kept on these drugs. All movement from the warehouse control room into the pharmacist dispensing station are recorded in the independent inventory control system. All controlled drugs are dispensed in a separate secured pharmacist station.

9. What protections are taken in order to insure the highest quality control possible in the repackaging of drugs?

The Company is not a repackager of drugs.

10. With regard to record-keeping, describe the records kept by your company with regard to the dispensing of mail order prescriptions?

(a) Original prescriptions are kept on file for five years. Each are filed by "an internal Rx number" which is the computer generated identification number that also appears on the prescription label.

(b) Each medication dispensed for a patient together with any information provided by the patient becomes part of the Patient Profile. The Patient Profile is accessible to the registered pharmacist, customer service representatives and pharmacy supervisors, via CRT. Data is stored for each medication dispensed for approximately 18 months, and it can be accessed by either the participant's ID number (usually the social security number) or name or by the Rx number for a specific medication.

(c) Customer service inquiries (telephone and written) are logged and retained for a period of three months.

(d) Certain program sponsors have requested record keeping procedures in addition to those outlined herein.

11. How do these record systems work when there is a need to recall a specific drug?

For a period of 18 months, the drug information can be accessed via a CRT by patient social security number, patient name, or Rx number. After such time, it is accomplished through the physical prescription file. The use of word "recall" is ambiguous. If there is a recall of a certain drug by manufacturer, the Company can identify all instances where such medication has been dispensed. In this event the Company's system is clearly superior to a non-computerized pharmacy.

12. How do these record systems work in helping protect the consumer against adverse drug interaction?

As previously noted, National utilizes the Adverse Drug Interaction Module marketed by First Data Bank (a subsidiary of Hearst Electronic Publishing) in the screening of all prescriptions. Whenever a prescription is entered into National's computer system, the module permits it to be checked against the patient's profile and identifies any possible adverse drug interactions. In the event that an interaction is identified, the module provides a description of the chemical effect and severity of the interaction. All appropriate references to Hantsen's Drug Interaction, Facts and Comparisons, and Data Central Drug Interaction Update Bulletins, two of the leading reference sources in the field, if further research is required.

First Data Bank's module contains over 100,000 products and is supplemented as new drug products appear on the market. The modules interaction classes are also reviewed and updated on a regular and timely basis as a result'of current clinical studies.

13. How quickly can these record systems be accessed when there is a customer complaint with regard to a mail order prescription?

Access to the on-line data which covers approximately 18 months of patient history takes only seconds to retrieve. Hard copy prescriptions •inquiries for prescription dispensed during the prior 12 months can be obtained in a matter of minutes.

14. When you dispense a mail order prescription, do you follow the appropriate laws and regulations of the state where the mail order prescription is being delivered? If not, why not?

Each of the Company's mail service pharmacies is licensed by the state in which it is located. Each facility is in full compliance with all applicable state and federal laws and regulations.

The legal propriety of mail service prescription drug programs is based on the position that such programs are subject to regulation only by the state in which the dispensing facility is located and, of course, applicable federal regulation. For example, if the dispensing facility servicing a program for a client in the State of New Jersey is situated in Tampa, Florida, then the program and the practice of pharmacy thereunder would be subject to regulation by the State of Florida and by all applicable federal regulations. The mail service pharmacy would not be subject to regulation by any of the states outside of Florida into which it dispenses prescription drugs.

This position is based upon time-honored concepts and principles of constitutional law. It is a general rule, applicable to all jurisdictions, that a corporation, such as a mail service pharmacy, which contracts for the shipment of its goods into another state is engaged in interstate commerce. The Commerce Clause of the Constitution of the United States of America gives to the United States Congress the power to regulate interstate commerce. If the United States Congress has exercised its power to regulate a specific aspect of interstate commerce, the ensuing federal regulation pre-empts further state regulation.

In the alternative, even if one were to take the position that a state is not pre-empted from regulating that aspect of the federal regulation, the attempt of any state to regulate other than the state in which the dispensing facility is located would be found to be inconsistent with, and otherwise prohibited by, the Commerce Clause of the Constitution of the United States.

The position that mail service pharmacies are regulated by the laws of the state in which the dispensing facility is located and by federal regulation has met with great support by those people who are charged with the proper enforcement of the law. Attorneys General in many states have written formal Opinions supporting this position, and Boards of Pharmacy in those and other states have likewise agreed that local licensure is inappropriate. Most recently, some states, such as Florida, have worked closely with the Company, the AARP Pharmacy Service, and others to promulgate legislation which serves to regulate mail service pharmacies in a manner short of local licensure, but nonetheless viable in support and effect from both a professional and constitutional standpoint.

It is important to note that there are extensive state and federal regulations applicable to the practice of pharmacy, and mail service prescription programs are subject to such regulations to the same extent as are retail pharmacies. The federal and state regulatory bodies responsible for enforcing such regulations have conducted at least ten (10) on-site visits to Medco's pharmacies thus far this year.

A. Federal Regulation

The Controlled Substances Act of 1970 (the "Controlled Substances Act"), enforced by the Drug Enforcement Administration of the Department of Justice (the "DEA"), establishes standards concerning the labeling, packaging and dispensing of "controlled" substances by pharmacists. In addition, the Food and Drug Administration controls the manufacture and distribution of drugs in the marketplace, including review of drug effectiveness, quality, sources, etc. With respect to mail service in particular, the U.S. Postal Service regulations govern the mailing of prescription drugs and conformity to specific regulations.

The Federal Trade Commission (the "FTC"), through its Bureau of Competition, reviews the regulations of all states to determine the extent to which such regulations compromise or restrict consumer welfare. To the extent that state regulation restricts consumers choices in the marketplace, the FTC must be convinced that consumer harm may occur absent such regulation. In reviewing the issue of mail service pharmacy, the FTC recently concluded that there is no merit to the argument for more restrictive regulations.

B. State Regulation

Each state has statutes in effect which regulate pharmacies dispensing within their borders. These requirements are issued and enforced by an administrative body (typically a pharmacy board) which is empowered to impose sanctions for noncompliance. The various state pharmacy boards, among other things, control licensing regulations and maintain continuing education requirements. Although state enabling statutes prescribe general licensing and practice requirements, it is the state pharmacy boards that are most actively involved on an on-going basis in establishing, implementing and enforcing specific rules and regulations regarding the pharmacy profession to ensure that the public health is protected.

State laws and regulations comprehensively govern matters such as who may write and dispense prescriptions, how prescriptions must be filled, how prescription drugs and controlled substances must be stored and safeguarded, what records must be maintained and when generic drugs may be substituted. In addition, under the laws of all the states in which the Company operates pharmacies, each prescription must be filled under the personal supervision of a registered pharmacist who personally inspects each medication and its label.

In addition, the National Association of Boards of Pharmacy (the "NABP"), founded in 1904, serves all but two state boards of pharmacy in matters of reciprocity and applications for licensure, uniform examination for licensing, and other matters of mutual concern to state pharmacy boards.

A dissatisfied mail service prescription drug recipient may contact the pharmacy board in his or her state of residence, and such board will contact state pharmacy board in the state in which the dispensing facility is located, either directly or through the NABP. The Company has satisfactorily resolved incidents through this procedure.

C. Oversight by Plan Sponsors

In addition to the active enforcement of regulations by the applicable federal and state authorities, Medco's mail service prescription operations are subject to oversight and scrutiny by the benefit managers of the plans serviced. Instances of participant dissatisfaction are communicated to the medical director of the plan sponsor who actively pursues satisfactory resolutions of such incidents.

D. Controlled Substances Act

The Controlled Substances Act, was established to improve the administration and regulation of distribution and the dispensing of "controlled" substances. The Controlled Substances Act places statutory responsibility on pharmacists by permitting pharmacists to dispense "controlled" substances only pursuant to written prescription orders, or oral orders communicated by physicians authorized to prescribe controlled substances and with written follow-up. And, of equal importance, the Controlled Substances Act maintains and enforces standards of quality with respect to pharmacists by means of regulating, among other things, the areas of inspection, packaging, record keeping, inventories, etc. Because in every state pharmacists are subject to the provisions of the Controlled Substance Act, a comprehensive body of federal law ensures that standards of quality and control are maintained.

Officials of both the Drug Enforcement Administration and the Food and Drug Administration have visited the Company's pharmacies on several occasions and reviewed the pharmacy activities conducted at such locations.

E. Enforcement of State Regulation

State pharmacy boards have adopted comprehensive rules and regulations applicable to pharmacies operating within their respective jurisdictions. Mail service prescription drug programs are subject to regulation only by the state in which the dispensing facility is located and, of course, applicable federal regulation. This position is based upon, among other things, well-recognized concepts and principles of Constitutional law regarding the regulation of interstate commerce. Attorneys General in many states have written formal Opinions supporting this position, and Boards of Pharmacy in those and other states have likewise agreed that local licensure is inappropriate. Recently, some states, such as Florida, have worked closely with the Company, the AARP Pharmacy Service and others to promulgate legislation to regulate mail service pharmacies in a manner short of local licensure, but nonetheless viable in purpose and effect from both a professional and constitutional standpoint.

Moreover, the on-going activities conducted by the various state pharmacy boards amply demonstrate that boards actively enforce and monitor pharmacy regulations. In 1985, for example, the state pharmacy boards in the six states in which the Company conducts dispensing operations, suspended 105 pharmacist licenses and revoked another 36 licenses. Interestingly, not one of these suspensions or revocations is believed to have been directed against a pharmacist in the employ of a mail service pharmacy.

These activities demonstrate that not only do pharmacy boards promulgate rules and regulations regarding the practice of pharmacy within their borders, but also play an active role in ensuring that such rules and regulations are enforced. Beyond this however, the Company maintains an "open door" policy with respect to its operations. In this regard, the Company actively communicates with the respective pharmacy boards in the states in which the Company operates pharmacies. Frequently, the staff and members of the boards informally visit. It is the position of the Company to also welcome on-site visits by out-of-state pharmacy boards. By way of recent example, invitations were extended to representatives of the pharmacy boards of the states of Arkansas, California and Texas to observe any of the Company's pharmacies.

F. Satisfaction of Out of State Inquiries

The state regulations and standards applicable to pharmacists practicing within their respective jurisdictions are essentially the same from state to state. This is evidenced by the fact that in order to obtain reciprocity with another state, 48 states require that the pharmacist seeking reciprocity take only a jurisprudence test in such other state, and not a licensing examination.

Given the fact that state pharmacy regulations are substantially similar in each state, and that active compliance and enforcement is pursued by state boards, a prescription drug recipient is assured that a claim against a pharmacist will be satisfied, regardless of whether the prescription is dispensed within such person's state of residence or is mailed from another state.

A person pursuing a claim against a pharmacy operating in such person's state of residence may contact the state pharmacy board within that state. A mail service prescription drug recipient who has a claim against an out-of-state pharmacy may pursue such claim by contacting the state pharmacy board in the state in which such person resides. Such pharmacy will then either contact the pharmacy board of the state in which the dispensing facility is located either directly, or through the National Association of Boards of Pharmacy, in order to initiate redress. The Company has demonstrated evidence that such practice can and does effectively operate.

For example, the Florida State Pharmacy Board in June, 1987, commenced an extensive investigation of the Company's Tampa pharmacy based upon information received from the Pennsylvania State Board of Pharmacy that a Pennsylvania resident had received a mail service prescription containing medication different from that prescribed by his physician. After a complete review of the Company's Tampa facility, the Florida Board concluded that the medication was properly dispensed in accordance with physician's orders. The board's report also noted that three registered pharmacists were involved in the filling of the prescription in question.

Further, at the request of the Washington State Pharmacy Board, on behalf of a mail service prescription drug participant in the State of Washington, the Nevada State Pharmacy Board undertook an investigation of the Company's Nevada pharmacy. Again, the Company was exonerated.

These clearly demonstrate that, as a matter of practice, a mail service drug recipient will receive the same response to his inquiries as a recipient residing in the state in which the prescription was dispensed.

G Oversight by Plan Sponsors

In addition to extensive regulation and oversight by the various state and federal regulatory bodies, unlike retail pharmacies, the Company's activities are subject to further scrutiny by the specialized resources available to the Company's clients (i.e., medical directors, pharmacy consultants, etc.).

Typically, the Company provides mail service prescription drug services for corporations, labor unions, insurance companies, and other entities referred to above, as part of employee health benefit packages. Accordingly, those persons responsible for adopting mail service prescription programs on behalf of their constituents are keenly aware of the nature of mail service pharmacy and the regulatory requirements applicable to the dispensing of prescription drugs. Medical directors of such entities often visit and review the particular Company pharmacy which will dispense their prescriptions, before adopting the Company's mail service program. Under the Freedom of Information Act, such entities occasionally request available reports prepared by the state pharmacy boards with respect to the applicable facility. Also, the Company provides references of other clients of the Company. Accordingly, as a matter of practice, an informed judgment based on all the facts is made by such entities prior to the selection of the Company's mail service prescription drug program.

As further evidence that the Company's mail service prescription programs are closely scrutinized by the Company's clients, such clients on occasion commission independent audits of the Company's pharmacies. By way of recent example, Mercer-Meidinger-Hanson conducted, on behalf of Mountain Bell Telephone, one of the Company's clients, an audit of the Company's Nevada facility. The audit reported that the "quality controls built into the system and the resulting level of accuracy, . . . [are] equal to or above that found in many local drug or chain stores." Of course, the Company monitors its operations through its own state of the art data processing systems.

Also, those persons who ultimately determine whether to adopt the Company's mail service program, are in many cases, responsible to the beneficiaries of the program. For example, in the case of health and welfare plans for union participants, the decision makers are elected by those very same union participants. Accordingly, a failure to select a program not responsive to the beneficiaries of the plan or which does not operate effectively, without regulatory intervention, will place such person's leadership in jeopardy.

The Company's mail service programs have an additional advantage not available to the recipient of a prescription order from a retail pharmacist. Participants in such programs have a representative and spokesman in the plan sponsor to whom they may address inquiries. Such plan sponsors may then act as advocates of the participant's claims.

In light of the foregoing, the Company, unlike local retail pharmacies, is subject to an additional level of scrutiny that ensures regulatory compliance and operational efficiency. The number of satisfied plan sponsors and patients testifies to such fact.

15. With regard to the safety and soundness of your mail order prescription operations, are you currently being sued in any state where you deliver mail order prescriptions?

National Rx Services, Inc. ("National"), a subsidiary of the Company, is being sued in the Court of Common Pleas of Franklin County, Ohio in the matter of Ohio State Pharmaceutical Association, et al. v. Franklin Z. Wickham, Executive Director of the Ohio State Board of Pharmacy, et al., Case No. 84CV-03-1776; however, this lawsuit does not concern the safety or soundness of mail service prescription operations. In fact, there are absolutely no allegations of unsafe or unsound mail service prescription operations made in that lawsuit by the plaintiff Ohio State Pharmaceutical Association or any other party.

16. Could you describe for the Subcommittee the nature of any pending suits?

The lawsuit consists of a complaint for declaratory judgment filed by the Ohio State Pharmaceutical Association, an association consisting of a minority of Ohio's pharmacists, the two other plaintiffs, against National, Franklin Z. Wickham, the Executive Director of the Ohio State Board of Pharmacy, and all of the Ohio public employee retirement systems. The only issues in the lawsuit are (1) whether pharmacists in Ohio may under state law fill prescriptions written by out-of-state practitioners who are not licensed to practice in Ohio; and (2) whether the Ohio public employee retirement systems are authorized under state law to enter into contracts with and disburse funds to National.

With respect to the first issue, National currently fills prescriptions in Ohio written by out-of-state practitioners who are licensed to issue prescriptions for drugs in another state, and, for controlled substances, are registered under the Federal Controlled Substances Act. The Attorney General of Ohio, in a formal Opinion (1982 Op. Atty. Gen. 82-043), opined that such a practice is not prohibited by Ohio law. Based on that Opinion, Board promulgated an administrative rule to specifically authorize and permit non-resident practitioners licensed in other states to write prescriptions for drugs to be dispensed by pharmacists in Ohio. The plaintiffs in the lawsuit are seeking a declaration that the administrative rule is invalid.

With respect to the second issue, plaintiffs seek a declaration that contracts entered into between the Company and the Ohio retirement systems, whereby the Company dispenses pharmaceutical products to retirees and beneficiaries under the various systems, are invalid because the retirement systems are allegedly without the specific statutory authority to enter into such contracts. The Company and the Ohio retirement systems contend that the retirement systems are authorized by law to enter into contracts to provide these prescription drug benefits for their members.

Neither of the fundamental issues in the aforementioned law relate to the safety or soundness of the Company's mail service prescription operations. In any event, the lawsuit is currently pending and there has been no adjudication on the merits to date.

MS. BARBER'S RESPONSE TO A WRITTEN QUESTION FROM SENATOR HEINZ

Question from Senator Heinz:

Please describe OPM's role in Blue Cross/Blue Shield's decision to award a contract for mail service pharmaceuticals. What factors were considered, and did these factors include cost to enrollee and/or quality assurance? Did OPM entertain competitive bids for the mail service contract?

Answer:

OPM had no role in Blue Cross/Blue Shield's decision to award a mail order drug contract or in its selection of a vendor. During the negotiations for the 1987 contract, Blue Cross/Blue Shield proposed adding a mail order drug program to its benefits package and OPM accepted the proposal. Reducing the cost of prescription drugs to Federal enrollees was definitely a factor in OPM's acceptance of the proposal. OPM was not aware of any quality assurance problems peculiar to the mail order segment of the pharmaceutical industry and hence, such issues did not enter into the decision.

Once a benefits package has been negotiated, the subordinate arrangements a carrier makes for the actual provision of medical services are the responsibility of the carrier and are not subject to OPM regulations, review, or approval. Hence, OPM did not entertain bids of any kind from mail order drug vendors and did not oversee the bidding procedure Blue Cross/Blue Shield employed.

MS. BARBER'S RESPONSES TO WRITTEN QUESTIONS FROM SENATOR MITCHELL

Questions 1 & 2:

Although a great deal of attention has been placed in the hearings on the drug benefits included under the Blue Cross/Blue Shield program, your testimony indicates that a number of other carriers (20) in the Federal Employees Health Benefits (FEHB) program also offer mail order presciption options for their beneficiaries.

a) Please provide a listing of the FEHB carriers that now offer such an option. Please include the year in which the mail order option was first offered.

b) Describe the deductible/copayment coverage offered by each carrier for retail and mail order prescriptions.

c) Identify the carriers who have a single source contract for mail order prescription services such as Blue Cross/Blue Shield does with Medco Containment Services.

I would like additional information on the prescription drug benefits to be provided to FEHB beneficiaries under the 1988 contracts.

a) Have negotiations for next year's FEHB contracts been concluded? If not, when do you expect them to be completed?

b) Please provide the information requested in Questions 1b and 1c for the upcoming year.

Answer:

A listing of FEHB carriers offering mail order drug programs is provided as Attachment A. (The list is identical for 1987 and 1988.)

Since we have now completed negotiations for next year's FEHB contracts, we can give you information on deductible and copayment levels in 1988. See Attachment B.

In 1987, all but one of the twenty carriers with mail order drug programs have single source contracts. The exception was the APWU Health Plan which has two contracts.

Questions from Senator Mitchell (continued)

Question 3:

Your written statement (p.3) says that OPM believes that mail order prescription options, "provide significant savings to our enrollees, particularly the elderly." Please provide the documentation upon which this position is based.

Answer:

Analysis of the information on deductibles and copayments provided in Attachment B (see previous question) reveals that most enrollees who participate in their plan's mail order drug program will realize significant savings. First of all, enrollees who purchase prescription drugs from a retail pharmacy must generally meet their plan deductible (an amount usually ranging from $200 to $250) before they receive any benefit payments for drugs. In contrast, mail order drug purchases generally require only a small copayment ($2 to $7) even if the plan deductible has not been met. Secondly, almost all FEHB fee-for-service plans cover retail pharmacy drugs on a coinsurance basis (i.e., the enrollee pays a fixed percentage of the cost). When it comes to higher-dollar drug purchases, the copayment approach is more advantageous to enrollees than the coinsurance approach. For example, under the Blue Cross/Blue Shield high option plan (see Attachment B), savings to the enrollee will accrue if the prescription drug purchase is more than $15. (20% coinsurance x $15 equals $3; mail order drug copayment is $3.)

The elderly as a group tend to use a higher volume of drugs and to use drugs which are more expensive than those used by younger enrollees. Therefore, the elderly will benefit more than most FEHB enrollees from a mail order drug program with a copayment feature.

While it is clear that enrollees who participate in mail order drug programs realize savings, there remains some uncertainty as to whether mail order drug options increase or decrease total costs for the FEHB Program as a whole. Theoretically, there should be savings because the mail order houses offer discounts to the carriers. However, there are some indications that mail order programs may result in increased prescription drug claims, thereby offsetting the effect of the discounts. For instance, because the plan deductible must be met before retail pharmacy drug purchases are covered while mail order purchases are covered from the outset, there will be some additional drug claims under a mail order program. Also, some believe that mail order drug programs, with their emphasis on extended-period prescriptions, are more likely to result in oversupplies of drugs that are never used. Another theory is that enrollees in plans with retail pharmacy drug benefits fail to file claims for some drug purchases (due to need to keep records and to fill out claim forms); in contrast, most mail order drug programs display a built-in reimbursement feature (i.e., the enrollee is in effect given an up-front purchase discount and pays only the fixed copayment).

Questions from Senator Mitchell (continued)

Question 4:

In its negotiations with carriers for benefits and premiums, does OPM maintain neutrality on the question of offering mail order prescription options for beneficiaries? If as your testimony indicates, there are significant savings to be realized through utilization of this option, should OPM remain neutral or should the agency push to have such mail order options included in all FEHB carrier contracts?

Answer:

The FEHB Program is very competitive and carriers are constantly looking for ways to enhance the attractiveness of their plans to enrollees. Because mail order drug programs offer convenience and economy to users of their service, 20 of the 24 fee-for-service carriers in the FEHB Program have added a mail order drug option without any encouragement from OPM.

If we were certain that mail order drug programs produced significant savings to the FEHB Program as a whole, OPM would probably encourage the remaining carriers to add the benefit (unless, of course, it is shown that mail order operations are not meeting safety standards set by responsible regulatory bodies). However, as explained in answer to the previous question, there remains some uncertainty about whether mail order drug programs generate overall program savings. At a time when insurance rates are increasing dramatically, we cannot afford to push carriers to add a benefit that might increase program costs--even if many enrollees would find the benefit attractive.

In our annual "call letter" providing instructions on 1988 rate and benefit negotiations (issued in March 1987), we told FEHB carriers that, contrary to earlier expectations, mail order prescription programs did not appear to reduce total expenditures for drugs. Accordingly, carriers who wished to add mail order programs were directed to design them on a zero cost increase basis. Also, carriers with such programs were encouraged to increase copayment levels to make them cost neutral.

To sum up, OPM has maintained neutrality with respect to the question of whether or not an FEHB plan offers a mail order drug program. However, we have insisted that any new programs offered be designed to minimize the possibility that overall drug costs will increase.

ATTACHMENT A

Plans which now (1987) offer a mail order drug program and the year in which the program was first offered:

Aetna	86
AFGE	87
Alliance	86
APWU	86
ACT	87
BACE	86
BC/BS	87
Federal Managers	86
Foreign Service	86
GEBA	86
NAGE	86
NALC	87
NAPUS	87
NATA	87
NFFE	87
NTEU	86
Postal Supervisors	87
Postmasters	85
Rural Carrier	86
SAMBA	86

ATTACHMENT B

Deductible/copayment coverage offered by carriers for retail and mail order drugs for 1988:

	Mail Order Co-pay		Retail - Deduct/Emp. Coinsurance	
	Sole or High Option	Standard Option	High Option	Standard Option
Aetna	$7 ($3 if generic)	$7 ($5 if generic)	$200/20%	$250/25%
AFGE	$5	N/A	$200/20%	N/A
Alliance	$2	$3	$225/20%	$275/25%
APWU	*	-	*	-
ACT	$3	-	N/A	-
BACE	$2	-	$200/20%	-
BC/BS	$3	$5	$200/20%	250/25%
Federal Manager	$6	-	$250/25%	-
Foreign Service	$3	-	$175/20%	-
GEBA	$4	-	$250/25%	-
NAGE	$3	$3	$200/20%	$250/25%
NALC	$3	-	$150/25%	-
NAPUS	$4	-	$200/25%	-
NATA	$2	-	$200/25%	-
NFFE	$3	$3	$5 (Copay)	$5 (Copay)
NTEU	$2	-	$250/25%	-
Postal Supervisor	$5	-	$250/25%	-
Postmasters	$5	$7	$200/20%	$275/25%
Rural	$3	-	$250/20%	-
SAMBA	$5	-	$200/80%	-

* In the APWU Plan, mail order drugs are subject to the same deductible and coinsurance levels that apply to retail pharmacy drugs. After satisfying a $175 Plan deductible, APWU enrollees pay 15% of drug costs as long as their total covered expenses are $500 or less, and then pay 25% of drug costs thereafter.

STATEMENT OF

DAVID H. LAW, M.D.

DEPUTY ASSISTANT CHIEF MEDICAL DIRECTOR

FOR CLINICAL SERVICES

DEPARTMENT OF MEDICINE AND SURGERY

VETERANS ADMINISTRATION

BEFORE THE SUBCOMMITTEE ON GOVERNMENT EFFICIENCY,

FEDERALISM, AND THE

DISTRICT OF COLUMBIA

OF THE COMMITTEE

ON GOVERNMENTAL AFFAIRS

UNITED STATES SENATE

AUGUST 6, 1987

Mr. Chairman and Members of the Subcommittee:

I appreciate the opportunity to appear before your Subcommittee to discuss the Veterans Administration Mailout Prescription Program.

Pharmaceuticals or medications are provided by the Veterans Administration (VA) as an important treatment component of comprehensive health care services to eligible veterans.

Over the years, VA's mailout prescription program has served as an important adjunct to the total pharmaceutical services offered veterans. The program offers advantages to both the veteran patient and the VA health care system. Patients avoid waiting times for prescription refills and the necessity to travel, sometimes long distances, to dispensing pharmacies. For the individual medical center or outpatient clinic, the mailout program allows the pharmacy services to effectively and efficiently manage the use of staff, space and equipment. In FY 1986, the total number of outpatient prescriptions dispensed by VA pharmacies was over 51 million with an average prescription ingredient cost of $6.33 of which twenty-eight million prescriptions were delivered through the mail.

We feel it is important to stress the uniqueness of the VA with regard to this program. The VA's mailout prescription service dispenses prescribed medication from 172 VA medical centers and 226 outpatient clinics only to entitled veteran patients who reside within a given medical center/outpatient clinic service area. The same high quality pharmacy service given to veteran patients who present at the medical center or clinic are provided to all veterans in the mailout presription program. These services include the maintenance of a computerized patient medication profile, review by pharmacists of the patient's drug regimen and drug utilization, monitoring of potential drug interactions and inapproprite concurrent drug combinations. Other unique facets of the VA's mail-out program are:

- o Prescribed medications are dispensed free of charge as a continuum of comprehensive health care.
- o VA mandates and priority require the Mailout Prescription Program to be cost-efficient, accountable, and capable to prevent fraud and reducing waste.

- The VA normally dispenses a 30-day supply of medication with refills provided as appropriate.

- At least every 6 months, or sooner if indicated, the patient's medication regimen is assessed by the physician.

- The average medication ingredient cost of mailout prescriptions is significantly less than the private sector according to the General Accounting Office and reports by the VA Inspector General.

- Each VAMC has a Pharmacy and Therapeutics Committee comprised of pharmacists, physicians, nurses and other health care providers to establish local policy and procedures which include a drug formulary to ensure the cost-effectiveness and quality of drug use.

- Only routine medications are delivered through regular mail. Controlled substances prescriptions are mailed with a "return receipt requested."

A recent random survey by VA Central Office Pharmacy Service of five selected VA medical centers indicated:

- The overall Mailout Prescription Program is described by the chiefs of pharmacy service to be rated as good to excellent.

o That less than one to two valid complaints occurred out of an average of 918 mailout prescriptions per day per facility. Almost all of the complaints were related to timeliness of receiving medications, e.g., a late request by the veteran, postal delays on holidays and long week-end delivery, special request or more than 30-day supply of medications to go on vacation, failure to receive prescriptions, etc.

Continued efforts to improve our mailout prescription program are in the areas of the timeliness of service, development of more efficient computer software and automatic dispensing systems.

In conclusion, thank you for your interest in the Veterans Administration and for allowing us to share with you our mailout prescription program operation. My staff, and I will be happy to answer any questions concerning our program operation.

Attachment

VA OUTPATIENT PHARMACY PROGRAM

FACT SHEET

-FY 1986-

TOTAL NUMBER OF OUTPATIENT PRESCRIPTIONS -----------51,081,002

AVERAGE PRESCRIPTION INGREDIENT COST ---------------$6.33

TOTAL NUMBER OF MAIL-OUT PRESCRIPTIONS -------------28,126,548

TOTAL NUMBER OF FEE BASIS PRESCRIPTIONS ------------4,780,672

NUMBER OF RX FILLED BY PARTICIPATING PHARMACY -------352,167

COST PER PARTICIPATING PHARMACY PRESCRIPTION --------$15.78

NATIONAL ASSOCIATION OF MAIL SERVICE PHARMACIES
One Prince Street • Alexandria, Virginia 22314 • 703-684-8242

STATEMENT

OF

THE NATIONAL ASSOCIATION OF MAIL SERVICE PHARMACIES

ON

MAIL SERVICE PHARMACY PROGRAMS

BEFORE THE

SUBCOMMITTEE ON GOVERNMENT EFFICIENCY,
FEDERALISM AND THE DISTRICT OF COLUMBIA

OF THE

COMMITTEE ON GOVERNMENT AFFAIRS

UNITED STATE SENATE

AUGUST 6, 1987

Good Morning, Mr. Chairman. My name is Robert Waspe. I am an attorney and employed by Thrift Express Pharmacy, Inc. I am pleased to be here today to represent the National Association of Mail Service Pharmacies and to present the Association's statement in response to your written invitation and list of particulars. In addition to the Association's statement, individual NAMSP member companies have submitted written statements for the record.

The National Association of Mail Service Pharmacies represents and promotes the general interests of mail service pharmacies and the consumers they serve. NAMSP was established in 1976. All members must maintain pharmacy licenses in good standing in every state in which they operate a dispensing facility and all members must have dispensed at least 100,000 prescriptions per year by mail for at least two years prior to becoming eligible for membership.

Its members currently include the major mail service pharmacies in the U.S.: the AARP Pharmacy Service, America's Pharmacy, Health Care Services, Medco Containment Services, Pharmacy Management Services, Baxter Prescription Services (a division of Baxter-Travenol), Thrift Express Pharmacy Services (a division of J.C. Penney), and Walgreens C.P.O..

Consumers who are served by mail service pharmacy include, among others: the members of American Association of Retired Persons (AARP), the Aluminum Company of America, the Arthritis Foundation, the Epilepsy Foundation, the State Employees of New York, the State Employees of Ohio, the State Employees of Florida, the Texas Retirement System, the State Employees of Maine, the International Ladies Garment Workers Union, the United Auto Workers, General Motors and employees of many of the Fortune 500 companies.

MAIL SERVICE PHARMACY--A BRIEF HISTORY

Mail service delivery of prescription drugs has existed since before the invention of the automobile. Rural Americans often depended on their letter carriers to deliver their medications from the drug store of a distant town. In the early decades of this century right up until today, both consumers and druggists themselves have relied on the mail or common carriers to deliver prescription medication either to their homes or their drug stores, respectively.

Impetus for institutional growth in mail service pharmacy originated from within the U.S. Government. In 1946, the Veterans Administration instituted a mail service pharmacy program to provide prescription benefits to veterans returning from World War II. Today, the VA's mail service program is by far the largest program in the country, dispensing more than 20 million prescriptions annually. Between 1946 and 1966, several mail service pharmacies were established in the private sector. In 1959, the AARP Pharmacy Service, a NAMSP member since the association was formed, was established to ensure that older Americans (especially the homebound and/or rural residents) had access to lower priced, high quality prescription medications.

In the last several years, mail service pharmacy has experienced growth due to employer and union groups' mutual concern with rapidly rising health care costs. According to an April 1987 Arthur D. Little report, mail service pharmacy has grown from a $100 million a year industry in 1981 to approximately $750 million in 1986, a large portion of which is represented by the VA program's volume. NAMSP member companies dispense approximately 20 million prescriptions a year which are delivered by mail or common carrier. However, together, the VA and all private mail service pharmacies' volume account for only 4% of the $21 billion U.S. prescription market.

MAIL SERVICE PHARMACY OPERATIONS

The Regulatory Environment

Mail service pharmacies are extensively regulated. Like every operating community pharmacy in the U.S., mail service pharmacies are fully licensed and fully approved by the Board(s) of Pharmacy of the states in which they are located. Like all pharmacies, they must fully comply with the state pharmacy laws and regulations of their resident states. Like all pharmacies in America, mail service pharmacies are registered with the U.S. Department of Justice and must fully comply with the statutes and regulations of the Food and Drug Administration and the Drug Enforcement Administration, specifically in the latter case, with the Drug Abuse Prevention and Controlled Substances Act of 1970.

In short, mail service pharmacies must comply with same regulations governing security, inventory, storage, recordkeeping, the proper use of licensed and support personnel, generic substitution and the dispensing of controlled substances as any other pharmacy located in the same state. Mail service pharmacies employ only fully licensed and fully approved pharmacists in their facilities and, of course, like any other pharmacy, mail service

pharmacies are subject to inspections and disciplinary actions by their respective state Board(s) of Pharmacy and the Drug Enforcement Administration.

Competitors of mail service pharmacy have endorsed and initiated both regulatory and legislative attempts on a sate-by-state basis which have as a goal the proposition that a mail service pharmacy should be licensed in and subject to the laws and regulations of every state in which it has a patient. To date only five jurisdictions have adopted such a requirement. However, each jurisdiction has been reluctant to attempt to enforce these licensure requirements because of severe constitutional infirmities under the Commerce Clause.

Mail Service pharmacies have taken the position that restrictions against the free flow of interstate commerce require them only to be licensed in the states where they are located. To date, many Attorneys General who have reviewed the issue are in agreement: indeed, one Attorney General, who had previously ruled that licensing of an out-of-state pharmacy was constitutional, subsequently refused to prosecute because the relevant Board of Pharmacy could not provide any evidence that out-of-state pharmacies endangered the public health.

We would add that the California Board of Pharmacy, after an 18-month inquiry into the alleged dangers of mail service pharmacy, concluded in October 1986 that there was no credible evidence to support the position that mail service pharmacies (either in-state or out-of-state) constituted a threat to the public health and safety. This is precisely the same conclusion reached by every other official investigation conducted on mail service pharmacy, including studies by the BNDD, the FTC and the DEA.

Operations-General Considerations

NAMSP is an association of companies engaged in mail service pharmacy. Naturally, each company competes. As such, NAMSP is not privy to proprietary procedures, systems design, software, hardware or information. Such information is the property of the companies.

NAMSP member companies all practice team pharmacy. NAMSP company dispensing pharmacists do not sell beachballs or fertilizer, stock shelves, intake inventory, ring the cash register or deal with salesmen. NAMSP company pharmacists are dedicated to discrete functions within the dispensing process. Typically, one group of pharmacists validate and verify prescription orders, other groups take telephone prescriptions or call physicians to clarify medication orders, other dedicated pharmacists answer patients questions about their medications, others deal with salesmen or supervise either data entry personnel or technicians working in prepack units, other pharmacists dispense prescriptions only for controlled substances but most important, those who dispense, only dispense.

Support personnel, or pharmacy technicians, are employed consistent with relevant state pharmacy law guidelines. In nearly every U.S. jurisdiction, only licensed pharmacists or pharmacist-interns (pharmacy students in an accredited pharmacy program) under the direct supervision of a licensed pharmacist may dispense a legend drug.

The use of conveyer belts, moving files and computerized record keeping greatly increase productivity. While we are advised that no company has established productivity "quotas", we understand that all companies have normal business expectations about productivity guided by the paramount consideration that productivity cannot interfere with accuracy or professional judgment.

SAFETY CONSIDERATIONS

Patient Safety

Every NAMSP pharmacy has established extensive quality assurance checks and balances within its respective dispensing process. We understand that, in no case, is a new prescription reviewed by fewer than two pharmacists: in most cases, we are told that three or more pharmacists will review a prescription before it is shipped.

Every NAMSP pharmacy maintains computerized patient profiles which accurately and instantaneously can recall each and every drug, prescriber, dosage strength, authorized refills, refilled dispensed, etc.. These profiles enable the pharmacies to provide sophisticated, proprietary drug interaction software to ensure that all drugs dispensed by the individual pharmacy to the individual patient are not contraindicated. When patients provide information about their allergies, this information can also be added to the drug interaction software. At data entry, all prescriptions must clear the interaction screen before a label can be printed and the prescription sent to a dispensing pharmacist. Such quality assurances are augmented by verifying the prescriber's DEA number on each prescription: this is accomplished by an on-line check of the number itself and, if necessary, use of the American Medical Directory.

When the prescription order reaches a dispensing pharmacist, supplementary warning labels are added where indicated (e.g., warnings against operating a vehicle or drinking alcoholic beverages). Additionally, NAMSP member companies often supplement the labeling information with additional patient consultation information, including the name of the drug, the condition for which it is prescribed, how to take it, how to store it, what to do if a dose is missed, possible side effects and what to do if the side effects or adverse reaction occur.

- All NAMSP member companies provide toll-free 800 number telephone service so that patients have easy access to a pharmacist within the facility who has readily retrievable access to patient records in order to answer questions. This toll-free service is provided during all working hours and, by several companies, at least six days a week.

All NAMSP companies have strict inventory controls. Purchasing their inventories primarily through recognized national primary wholesalers or directly from the manufacturers, all inventory is checked at receiving for damage, expiration date, strength, supply and drug code number. Because most NAMSP companies turn their inventories 12-14 times a year, outdated drugs are rarely a problem: in most cases, any product received in a factory container whose expiration date is within six months of delivery is not accepted.

Most, if not all NAMSP companies "prepack" their fastest moving inventory within their respective facilities. Under careful supervision of licensed pharmacists, support personnel break larger supply factory containers of "high velocity" products and prepack them into the most frequently prescribed quantities. Such prepacked products are bar-coded to track them to the original factory containers in the event of a manufacturer's or regulatory authority's recall order.

Drug Diversion

Security against drug diversion is of critical importance to NAMSP members. Prescriptions for controlled substances are dispensed in separate and secure controlled substance "cages" or "rooms." All such controlled substances rooms meet or exceed federal and state physical security requirements. Most are equipped with both motion and infrared sensors.

As noted earlier, all prescribers' orders for controlled substances are verified by a check of the prescriber's unique DEA number, supplemented with random checks of telephone numbers, addresses and knowledge of patient identities.

NAMSP member companies also package prescriptions under separate secure conditions and nothing on the exterior of the package indicates in any way the identity of the contents, regardless of whether or not it contains a controlled substance. Moreover, DEA and postal regulations governing the shipment of both controlled non-controlled substances are rigidly obeyed.

Temperature Sensitive Entities

NAMSP companies employ a number of procedures designed to protect sensitive products from exposure to extremes of temperature. Some companies will not ship certain products, like insulin, to certain areas in specific months of the years. Others will not ship on specific days. Others ship temperature sensitive products in specially designed Styrofoam cool-paks, supplemented by additional package insulation. However, all NAMSP companies' packaging specifications meet or exceed the specifications of the manufacturers who, after all, ship these same products by common or private carrier to community and mail service pharmacies alike. Temperature sensitive products which are shipped routinely require a signature upon receipt at the point of delivery.

SAFETY RECORD

Because millions and millions of prescriptions are dispensed annually by human beings, errors are bound to occur. Such errors are made either through omission or commission and they occur in all practice settings, whether institutional, community or mail service.

Regardless of the practice setting, dispensing errors are made and no pharmacist can be proud of having made them. However, we are aware of no study or evidence that compares the respective error rates of the major practice settings. Certainly, there is no evidence that an error made in a mail service setting has anything intrinsically to do with mail service pharmacy.

We believe that the quality assurance procedures instituted in the NAMSP member companies have contributed more to prescription accuracy than in any other practice setting. One member company reported 73 errors of any nature out of 1.5 million prescription shipped in 1986. Another member company reported its insurer's analysis at 1 error every 385,000 prescriptions shipped. Do errors occur? Yes. Do we catch them within the facilities due to our procedures? Yes, in almost every case. Very few ever reach a patient's hands. Do we aspire to 100% accuracy? Absolutely.

The Subcommittee should also take into consideration the intense scrutiny under which NAMSP member companies must operate in filling prescriptions under major medical plans. Because the medical directors of those plans are obliged to pay for beneficiaries' hospital and physician expenses, they cannot afford to look the other way if second rate pharmacy is being practiced. In short, NAMSP members operate under greater scrutiny than most community pharmacies.

NAMSP member companies are ready and willing to have their accuracy records compared with those of any other practice setting. A revealing indicator of accuracy and professionalism would be the disciplinary proceedings of the Board(s) of Pharmacy in the states where mail service pharmacies are located. Ask those Boards to tell the Subcommittee which practice setting generates the largest number of complaints, either in absolute numbers or relative to the volume of prescriptions dispensed. It won't be mail service pharmacy. By way of example, one of our member companies conducted an informal study of complaints in a state where three NAMSP member companies have facilities. During the period 1979-1985, nearly 9,800 complaints were filed with the Board of Pharmacy against pharmacists or pharmacies: of those 9,800 complaints, only four could be attributed to mail service pharmacy.

CONCLUSION

To close, Mr. Chairman, we gratefully acknowledge your willingness to invite us to appear before you and your colleagues and offer our comments on how we practice pharmacy. For years and years, our competitors have appeared before legislative and regulatory bodies in attempts to make mail service pharmacy a less competitive alternative to community pharmacy. To our patients' credit and benefit, these attempts have, for the most part, failed. We ask you: should consumers or independent retail druggists determine which pharmacy services are available to the general public?

AARP
PHARMACY
SERVICE

Retired Persons Services, Inc.

One Prince Street
Alexandria, Virginia 22314
(703) 684-0244

F. NICHOLAS WILLARD
Director
Governmental Affairs

September 4, 1987

Denise A. Botsaris, Chief Clerk
Subcommittee on Government Efficiency,
Federalism, and the District of Columbia
U.S. Senate
Room 432--Hart Senate Office Building
Washington, D.C. 20510-6250

Re: Supplemental Questions and Responses of the National Association of Mail Service Pharmacies following Senate Oversight Hearings on the Safety and Soundness of the Mail Order Drug Industry (August 5-6, 1987)

Dear Ms. Botsaris:

Please find enclosed the responses of the National Association of Mail Service Pharmacies (NAMSP) to the supplemental questions posed by Senators Heinz and Mitchell following the NAMSP testimony presented by Mr. Robert Waspe of Thrift Express Pharmacy, Inc., on August 6, 1987.

Mr. Waspe forwarded the questions to Del Konner, Pharm.MS., the executive director of NAMSP, who subsequently requested that the AARP Pharmacy Service coordinate the efforts of NAMSP members to respond to the Senators' questions. We are hopeful the enclosed information will be helpful in completing the hearing record.

Sincerely,

F. Nicholas Willard

Supplementary Questions and Responses
by the
National Association of Mail Service Pharmacies
for the
U.S. Senate Subcommittee on Government Efficiency,
Federalism, and the District of Columbia
September 4, 1987

I. Questions from Senator George J. Mitchell

1) Your written statement (p.1) lists three criteria companies must meet in order to be members of your Association. What other criteria are necessary for membership in your Association?

Answer: **They must make application, demonstrate the validity and good standing of their current pharmacy license(s), submit a copy of the most recent inspection report from their respective state regulatory board or authority and, upon request, allow for a tour of their facilities. Naturally, all NAMSP members must attest that they comply with all relevant State and federal regulations and that they practice to the highest professional standards of pharmacy.**

2) Please provide NAMSP's official policy on the following issues:

a) appropriate pharmacist/technician ratios;

Answer: **NAMSP member companies must comply with all relevant state laws and regulations concerning the ratio of pharmacists to technicians in those discrete tasks within the dispensing process which require the professional judgment of a licensed pharmacist. In most states, this ratio is established at 1:1. However, in other states, the ratio may be 1:2.**

b) generic substitution:

Answer: **Regarding drug product selection, NAMSP member companies comply strictly with the generic substitution laws of the state in which the dispensing facility is located. In addition, NAMSP member companies only substitute those generic products which have been approved by the FDA as bioequivalent to their higher-priced brand name equivalents, provided such products are included on the respective formularies of those states which do not accept the FDA's approval process.**

NAMSP member companies always honor the intent and instructions of the prescriber and the patient with respect to substitution, provided those instructions are consistent with the laws of the state in which the dispensing facility is

located. For instance, state laws uniformly grant the patient the right to refuse to have a generic drug dispensed even though their physician, while writing for the brand name, may have authorized substitution.

However, there are some instances in which specific states' laws prevent a NAMSP member company from substituting even when both the prescriber and the patient indicate they have authorized a generic to be dispensed. By way of example, a Pennsylvania pharmacist was prevented from dispensing the generic propranolol for Inderal (regardless of the state from which the prescription originated) for more than 18 months unless the prescribing physician actually wrote the prescription for "propranolol." This resulted because Pennsylvania's independent drug formulary committee delayed the inclusion of propranolol into the state's positive formulary for 18 months after it was approved by the FDA.

c) patient consultation (your written statement says that NAMSP member companies often supplement label information with additional patient consultation information);

Answer: All NAMSP companies provide 800 toll-free telephone services to assure their patients' access to a pharmacist with access to patient records if the patients have questions about the drugs they are taking (e.g, storage, how to take it, dosage appearance, etc.). Patients can use this service either prior to the dispensing of their medication or after they have received it. Additionally, NAMSP member companies provide written information about the drugs they dispense. The AARP Pharmacy Service's MILS (Medication Information Leaflets for Seniors) program was one the first of its kind, offered routinely long before community pharmacies began offering written information. MILS are developed with the cooperation and assistance of the FDA and a panel of pharmacologists and geriatricians. Typically, MILS include the following information: the name of the drug (both brand and generic), the conditions for which it is prescribed, how to take it, how to store it, what to do if the patient misses taking a dose, what the physician should know about the patient before prescribing it, what the possible adverse reaction could be and what to do should the reactions occur.

Health Care Services, Inc. of Bala Cynwyd, PA, also uses the AARP MILS patient consultation information leaflets. Medco Containment Services, Inc. utilizes the patient information leaflets developed by the USP. Baxter Prescription Services, Inc. provides written patient counseling information on all prescriptions dispensed which is generated from a computerized drug counseling data base. Thrift Express Pharmacy Service utilizes its PALs (Patient Advisory Leaflets) to provide patients with written home reference materials.

d) pharmacist/technician quotas in filling prescriptions;

Answer: With respect to the question of "quotas," NAMSP is silent. Its unstated policy is that productivity is the province of each member company, given the overriding guideline that productivity should not impair either accuracy or professionalism.

e) provision of replacement prescriptions in instances where the original mail order shipments are delayed or lost;

Answer: NAMSP has no official policy governing member companies' conduct with respect to the rare incidents in which a consumer reports that a shipment is delayed or lost. Common sense requires that the member company do what is necessary to resolve the patient's situation. In all cases, the member company would verify, using the patient profile, that (a) the order was received; (b) that the order was shipped and the patient billed; and (c) the patient's complete home address was correctly entered. If these conditions were verified, traces would be initiated through either UPS or USPS. Depending on the immediacy of the patient's need, the prescription would be refilled, so noted in the patient's profile and shipped either by USPS, UPS or overnight mail at no charge. If the prescription was for certain controlled substances, we believe member companies' policies are uniform: a new prescription would be required.

Of course, if any controlled substance is reported lost in shipment and the report cannot be resolved, the NAMSP member company reports the loss on Form 106 to the DEA, as required by the Drug Abuse Prevention and Controlled Substances Act of 1970.

Questions from Senator John Heinz

1) Are mail service pharmacies required to report all dispensing errors made at their facilities, or complaints made by the recipients of their products or services, to their respective state boards of pharmacy? If not, what steps are taken by your respective internal managements to acknowledge and rectify errors and/or handle customer complaints?

Answer: No pharmacy in the United States is required to report dispensing errors and/or complaints to its respective State Board of Pharmacy. Consumers and/or physicians make complaints about either dispensing errors or poor service from particular pharmacies or pharmacists to the respective Boards of Pharmacy. Practically speaking, this is the only mechanism by which the State Boards become aware of deviations from professional standards of practice. The respective Boards then initiate investigative inspections or informal hearings based on the complaints and publish the results of any disciplinary actions taken. By way of example, we attach a copy of the South Carolina Board of Pharmacy's August 1987 News (see p.2): this issue serves as an advisory to South Carolina's community pharmacists (there are NO large-volume mail service pharmacies in the state) on dispensing errors reported to and investigated by the Board.

The management of NAMSP member companies, as good pharmacists and good businessmen, must satisfy their patient and client concerns and/or questions. To the best of our knowledge, every NAMSP member company has established customer service departments to which their patients have access by mail or by virtue of the 800 toll-free telephone service uniformly offered by NAMSP companies.

The staff of these departments are charged with satisfying their patients whether it is a question regarding whether or not a prescription order has been received and/or shipped, when it will be shipped, whether the medication received is the medication the physician prescribed, has a generic drug been substituted, etc. If the question can be adequately handled by a trained customer service representative, it is; if the question requires the attention of a registered pharmacist (e.g., anything to do with dosage strength, storage, appearance, directions for use, etc.) the call will be appropriately routed.

2) Have your members' facilities been subject to random inventory audits and/or investigations by the respective state Board of Pharmacy, by the DEA or the FDA? If not, would you oppose such random investigations?

Answer: Yes, just like any other pharmacy in the United States, NAMSP member company facilities are subject to random audits, inspections and/or investigations carried out by Boards of Pharmacy, the DEA, the FDA, and/or any other state agency with jurisdiction over the practice of pharmacy.

3) How do customer guarantees of product quality and service differ between your respective members' mail service pharmacies?

Answer: Because all prescription drugs (both brand name and generic) available on the domestic market are approved by the FDA and manufactured to FDA standards, NAMSP member companies guarantees relative to prescription drug quality do not differ. NAMSP members routinely require independent assays on their generic products to verify the efficacy of formulations. Moreover, NAMSP member companies, to the best of our knowledge, purchase their inventories either directly from the manufacturers or licensed wholesalers; several NAMSP member companies require that wholesalers provide copies of their manufacturer's invoices when delivery is made to a NAMSP facility.

An apparent discrepancy between the guarantees of quality assurance of two NAMSP members which was pointed out during the Subcommittee hearings does not, in fact, exist. It is our information that the original mailer from Medco announcing its availability under the federal employee benefits program included the same guarantees as were found on the Thrift Express mailer. The Medco educational piece on which attention was focused was subsequent to the original mailer and was designed to serve as a supplement.

NAMSP is not aware of any material difference in member companies' consumer service guarantees.

4) How do pharmacists at your respective facilities verify information about and the identities of supposed prescription recipients who call in saying they have lost their refill slips but need a refill?

Answer: All NAMSP member companies maintain sophisticated, computerized patient profiles. These individualized profiles typically include the following information: (a) the patient's full name, address, telephone number and social security number; (b) where appropriate, the third-party or employer-health plan and policy number by which the patient is covered; (c) any allergies the patient has reported; (d) the name, quantity, dosage strength, date dispensed, prescription number and authorized refills for every prescription the facility has dispensed to the patient; and (e) the name, address, phone number, license number and DEA number of the prescriber of each of the patient's prescriptions. In addition, those NAMSP members which serve large third-party plans also have eligibility tapes provided by the employer or insurer: such tapes help the facility verify that the patient is currently eligible and provide the ONLY authorized address to which a prescription for that patient can be mailed.

With the above information immediately available, it is not difficult for a pharmacist to verify whether or not (a) the caller is who he or she claims to be and (b) whether or not the requested refill is appropriate based on the date the prescription was most recently dispensed or refilled. If this information can be verified, the refill can be dispensed and the fact that it has is then noted in the profile, appropriately indicating that one less refill is currently authorized.

STATEMENT OF THRIFT DRUG COMPANY,

A DIVISION OF J.C. PENNEY COMPANY, INC.

INTRODUCTION

Thrift Drug Company, a Division of J.C. Penney Company, Inc., deeply appreciates the opportunity to testify at these oversight hearings on mail order pharmacy.

The Thrift Drug Company was founded in 1935 by two Pennsylvania pharmacists.

With a commitment to service, quality and reasonable pricing, Thrift Drug opened its first store in Sewickley, Pennsylvania in May 1935 and the second in nearby Bellevue two weeks later. In all, three stores were opened that first year and the new Thrift Drug Company realized $200,000 in sales--a phenomenal success during the heart of the Great Depression.

Today Thrift operates more than 400 stores in 18 states and is guided by a management team that maintains that same commitment to customer service, quality products and performance.

In 1969, Thrift Drug became a division of JCPenney, the third largest retailer in the United States. Established in 1902, JCPenney became a member of the New York Stock Exchange in 1929. The JCPenney Company is headquartered in Manhattan, New York, and is a Fortune 100 company with over $14 billion in annual sales.

Throughout Thrift's 52-year history, the company has emphasized its prescription business--which still accounts for more than 40 percent of Thrift's total sales.

Thrift Drug employs more than 1,100 Registered Pharmacists and dispenses over 20 million prescriptions annually. Thrift employs eight full-time personnel recruiters to ensure qualified Registered Pharmacists are available at all times. Thrift also maintains a Student Aid Internship Development program which provides pharmacy students with financial assistance for their education and employment. Currently Thrift Drug employs 197 Student Interns and 100 Graduate Interns.

Along with an emphasis on pharmacy has also come a commitment to remain in the health care industry. Thrift's durable medical equipment business, Trust Health Care, began in June 1982 as a home medical equipment program that rents or sells products such as wheelchairs and hospital beds. Customers receive free home delivery, assistance from trained technicians and 24-hour emergency service.

EXPRESS PHARMACY SERVICES

Thrift Drug also operates Express Pharmacy Services, (EPS) a mail-order pharmacy, established in January 1983 in Pittsburgh. From a zero base of business that year, EPS has grown to four facilities and filled over 1.5 million prescriptions in 1986. Current projections show EPS will fill over 2.2 million prescriptions in 1987.

Created in response to the need to contain and reduce rising prescription drug costs, EPS supplies maintenance prescriptions (drugs taken regularly on a long-term basis) by first-class mail or UPS to member of groups and corporations nationwide.

Thrift's mail-order history began in January 1983 in a small facility at Thrift's Pittsburgh headquarters servicing their first account, the Pennsylvania State Employees. As one of the first chain drug companies to enter the mail-order prescription business, Thrift was a pioneer in this new health delivery field.

Supported by Thrift's chain-wide computerized pharmacy, Thrift was well prepared to offer the new service.

A turning point came in 1984 when agreements with corporate clients created substantial volume and, as business expanded, new facilities were needed. Currently four facilities operate in Pennsylvania and Alabama.

Today EPS serves nearly 300 companies emphasizing the following five areas:

- Reduction of Medical Costs to Patients and Corporate Sponsors
- Generic Substitution
- Controlled Dispensing
- Client Service and Convenience
- Quality Control

REDUCTION OF MEDICATION COSTS

Savings accrue from a sponsor negotiated source of supply for both the participant and the employer. EPS through its economies of scale, can provide lower cost dispensing of prescriptions by centralizing the prescription dispensing function. Administrative costs are also reduced through centralized billing and payment procedures. One statement is sent to each company every month and only one check must be issued, as opposed to the customary numerous claims and many separate checks issued to beneficiaries.

GENERIC SUBSTITUTION

Whenever possible and permissible by law, EPS maximizes the substitution of bio-equivalent generic drugs in place of the more expensive brand name counterparts. There is a 50%-80% savings which results when generics are dispensed versus brands. EPS uses one of the leading generic distributors in order to provide a product which is consistent in color, shape, and therapeutic effect.

CONTROLLED DISPENSING

Thrift Drug Company developed its own computerized pharmacy system for use in its retail pharmacies as well as the EPS facilities. This on-line system is known as "Rxtra". Through the Rxtra system, Thrift/EPS pharmacists can identify drug interactions, drug to allergy problems, and drug to health condition situations. Thrift/EPS retains a consultant from the School of Pharmacy at Duquesne University, Pittsburgh, Pennsylvania, to update information needed regarding drug interactions.

The Rxtra system provides for eligibility verification each time a prescription order is received by EPS. This prevents unauthorized use of the plan. The system also monitors and controls refill authorization. Computerized plan parameters are entered which prevent refills from being dispensed before a certain percentages of the previous prescription have been consumed. This methodology eliminates stockpiling of medication and helps to insure patient compliance. EPS's plan parameters provide a maximum 90 days supply of medication.

CLIENT SERVICES

EPS provides a professional installation team to ensure a smooth and efficient transition for the home delivery prescription service. An announcement kit and operations manual is customized by EPS and is given to each eligible member of the company or organization. EPS provides for functional servicing of every client account by providing direct access to a responsible servicing representative at Thrift Drug's headquarters.

Each EPS facility has at least 12 toll free (800) telephone lines which allow personal consultation with a Pharmacist, placement of refill orders, and price inquiries. An unlisted toll free (800) telephone number is provided to physicians for immediate response to prescription inquiries and consultations. Each participant is given a postage-paid order envelope initially, and a postage-paid reorder envelope with each order. Prescriptions are delivered through first class mail or by United Parcel Service. These features promote plan utilization and help the employer and participant to save money.

QUALITY CONTROL

Every prescription is reviewed by a Registered Pharmacist for potential drug interactions, using the Rxtra on-line Pharmacy system. Every prescription is filled only by a Registered Pharmacist in all of our facilities. Also, every prescription is reviewed and checked by a different Registered Pharmacist, in a separate quality control area, for accuracy and directed use. These quality control features give our patients and corporate clients comfort and confidence in Express Pharmacy Services.

EPS provides for associate accountability in every step of the prescription filling function. This is our assurance of company-wide quality service to all of our patients and sponsors. EPS provides for drug batch monitoring for all medications dispensed from our state of the art tablet counting machines (Baker automated dispensing units). Each time our dispensing unit is refilled, the lot number and expiration date from the stock bottle and the associate identifier is entered on a "log" card. In the unlikely event of a manufacturer's recall, EPS can provide a printout of all patients who had prescriptions filled from the recalled lot number

All packages mailed to our customers provide for confidentiality through a non-descript mailing label. Every package is either heat or adhesive sealed to provide for tamper resistance precautions. EPS is currently investigating tamper-proof seals to be attached to each vial of medication before it is packaged in the tamper resistant mailers.

EPS can demonstrate and has studied extensively cost savings through its mail order providership.

The general process of providing prescription drugs through EPS is:

- Customer provides:
    - allergies and medical condition
    - order form and prescription
- Eligibility verification
- Dispensing by a Registered Pharmacist
- Checked by another Registered Pharmacist in a separate Quality Control station
- Packaged and mailed

(Generally, prescriptions are dispensed, checked, packaged, and mailed within two business days of receipt by EPS.)

CONCLUSION

EPS benefits the patient in a number of ways. Mail Order prescription services offer a lower overall cost of medications than retail drug stores.

Controlled substitutions of a lower cost generic product when permitted by the patient's physician also offers substantial savings.

The convenience of home delivery is obvious to those limited by disabilities that prevent them from traveling to retail outlets. The convenience of not having to travel in bad weather or long distances to these retail outlets by those not restricted also enhances the home delivery benefit.

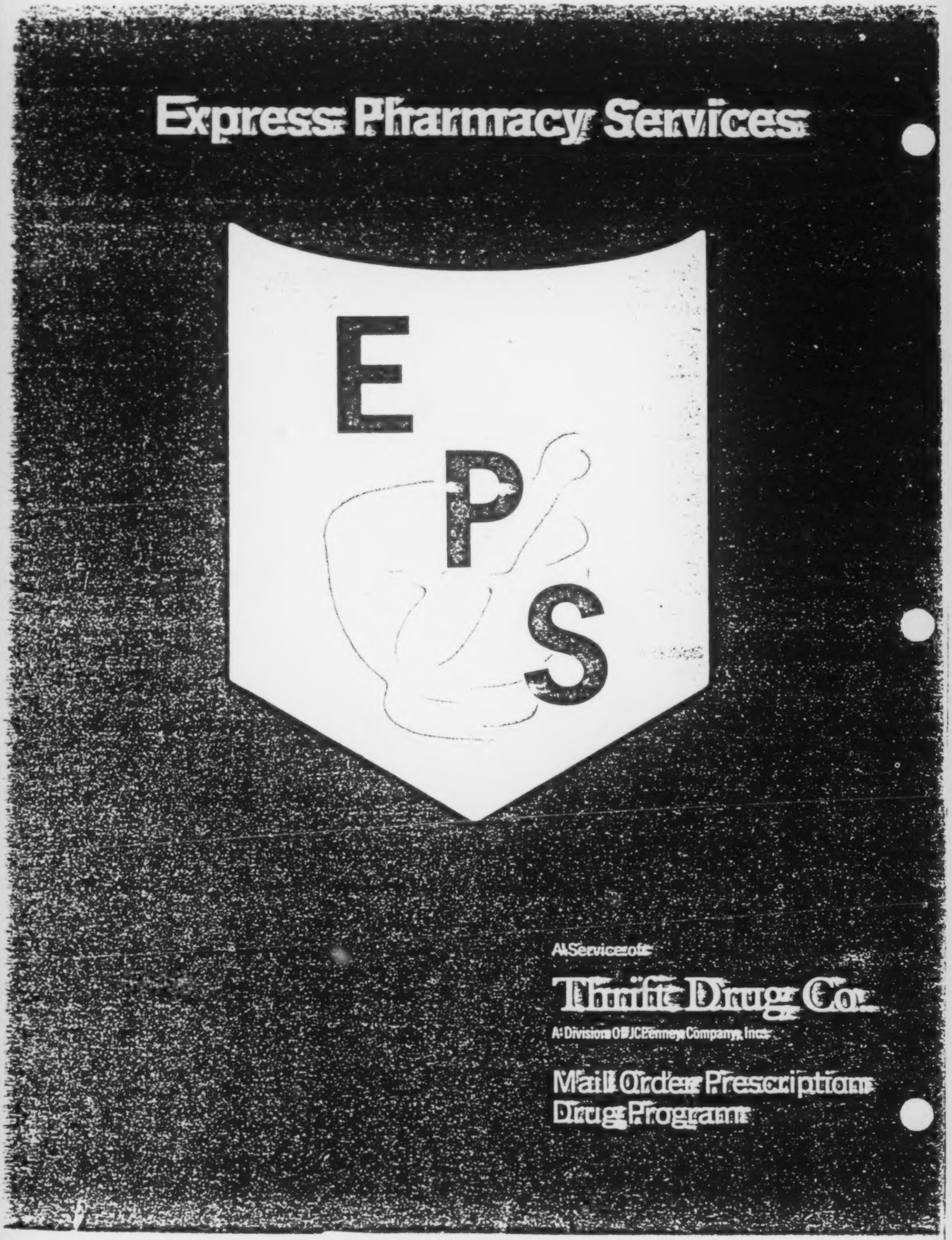
As explained earlier, Thrift Drug's Rxtra Pharmacy system monitors the patient's health-related conditions resulting in safer prescription dispensing. Attached hereto are samples of materials distributed by the Express Pharmacy Service as well as a recap of requirements for licensure of pharmacies.

We deeply appreciate the opportunity to provide this statement to the subcommittee and Thrift Drug Company hopes our testimony will be given careful consideration.

STATE BOARD REQUIREMENTS FOR LICENSURE OF PHARMACIES

Requirements	Mail Order Pharmacy	Retail Pharmacy
Pharmacy Permit	Yes	Yes
D.E.A. License	Yes	Yes
Pharmacy Equipment:		
Class "A" Balance	Yes	Yes
Apothecary Wts. (1/2 gr. to 1 oz.)	Yes	Yes
Metric Wts. 10 mg. to 50 gr.	Yes	Yes
Refrigerator	Yes	Yes
Heating Device	Yes	Yes
Graduates 1 cc to 40 cc	Yes	Yes
Mortars and Pestles (Glass & Wedgewood)	Yes	Yes
Spatulas (Stainless Steel and Non-Metallic Asst.)	Yes	Yes
Funnel 4 oz.	Yes	Yes
Funnel 16 oz.	Yes	Yes
Ointment Tile	Yes	Yes
Exempt Narcotic Record Book	Yes	Yes
Poison Register Record Book	Yes	Yes
Filter Paper	Yes	Yes
Powder Papers	Yes	Yes
Empty Capsules	Yes	Yes
Prescription Containers	Yes	Yes
Prescription Labels	Yes	Yes
Poison Labels	Yes	Yes
Auxiliary Labels Asst.	Yes	Yes
Prescription Filing Device	Yes	Yes
Current Pharmacy Act	Yes	Yes
Pharmacy Rules & Regulations	Yes	Yes
Federal Pharmacy Laws	Yes	Yes
State Pharmacy Laws	Yes	Yes
Photographs		
(1) 8 x 10 Exterior Photo showing Outside Sign	Yes	Yes
(1) 8 x 10 Photo from the Inside Entrance Facing Rear of Pharmacy	Yes	Yes

Requirements	Mail Order Pharmacy	Retail Pharmacy	Additional M.O.P. Stand.
(1) 8 x 10 Photo from Rear of Pharmacy Facing the Front	Yes	Yes	
(2) 8 x 10 Photos of Prescrip- Area Showing Contents	Yes	Yes	
Schedule of Hours which Pharmacy is Open	Yes	Yes	
Schedule of Working Hours if Each Pharmacist Employed	Yes	Yes	
Telephone with Number Shown on Prescription Label	Yes	Yes	
Reference Materials:			
Physician Desk Reference	Yes	Yes	
USP-NF	Yes	Yes	
Facts & Comparisons	Yes	Yes	
USP-DI			Yes
Redbook			Yes
Remington			Yes
Generic Formulary			Yes
Clinical Pharmacy & Therapy			Yes
Physician Desk Reference for Non-Prescription Drugs			Yes
Hanston's Drug Interaction			Yes
Pharmacy Law Digest			Yes
Compendium of Drug Therapy			Yes
Pharmacist License	Yes	Yes	
Auxiliary Label Chart			Yes
Patient Advisory Leaflets			Yes
Computerized Pharmacy System	Yes	Yes	
Computerized Statements	Yes	Yes	
Drug Interaction System	Yes	Yes	
Covered Waste Receptacle	Yes	Yes	
Skeleton Sketch of Pharm. Dept.	Yes	Yes	



Express Pharmacy Services

A Service of

Thrift Drug Co.

A Division Of J.C.Penney Company, Inc.

Mail Order Prescription
Drug Program

JCPenney

THRIFT DRUG

THRIFT DRUG

INTRODUCTION

Express Pharmacy Services, a Thrift Drug Company, specializes in a nation-wide prescription drug home delivery service for employees and members (participants) of major corporations and organizations (sponsors). Thrift Drug Company is a division of JCPenney, and operates 397 retail drug stores, in eighteen states, under the names of Thrift and Treasury Drug. Through over **50** years of successfully dispensing prescription drugs, we have earned the confidence and trust of our valued customers.

Our extensive experience serving the individual needs of our loyal customer following, while dispensing more than 20 million prescriptions annually from neighborhood drug stores, has provided Thrift with the sensitivity and concern evident in the quality service offered by **Express Pharmacy Services**. One important reason for our success is the more than 1,100 Registered Pharmacists in the Thrift family, offering a valuable and caring resource of professionals unmatched in mail order pharmacy.

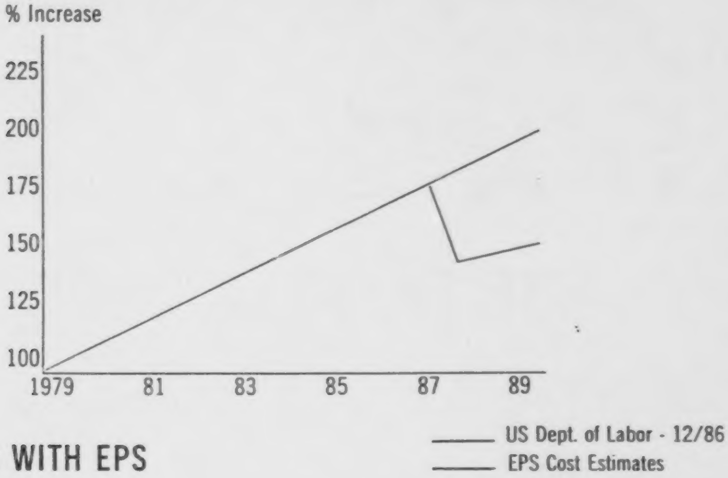
In addition to the value of Thrift Drug's extensive experience and commitment to excellence in providing prescription drug services, Thrift's parent, JCPenney, offers a special level of participant comfort.

JCPenney, a Fortune 100 company, has a distinguished history of success and a reputation for business integrity.

Express Pharmacy Services, Thrift Drug and JCPenney are pleased to offer a quality prescription home delivery plan which will not only prove cost effective and efficient for the sponsor and participants, but also provides the comfort of a business relationship with leaders in their respective industries.

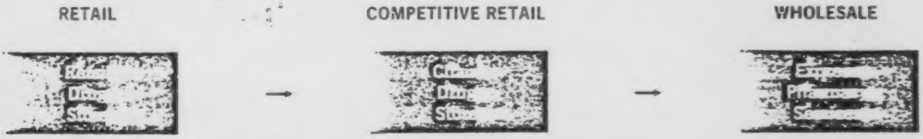
EXPRESS PHARMACY SERVICES COST CONTAINMENT OBJECTIVE

ESCALATING COST OF PRESCRIPTION DRUGS



SAVINGS WITH EPS

As the cost of prescription drugs and health care services has increased significantly in recent years, **Express Pharmacy Services** has developed a plan to move maintenance prescription (those taken regularly and continually for chronic conditions) buying practices to the highest level of efficiency and economy on a path which has progressed from:

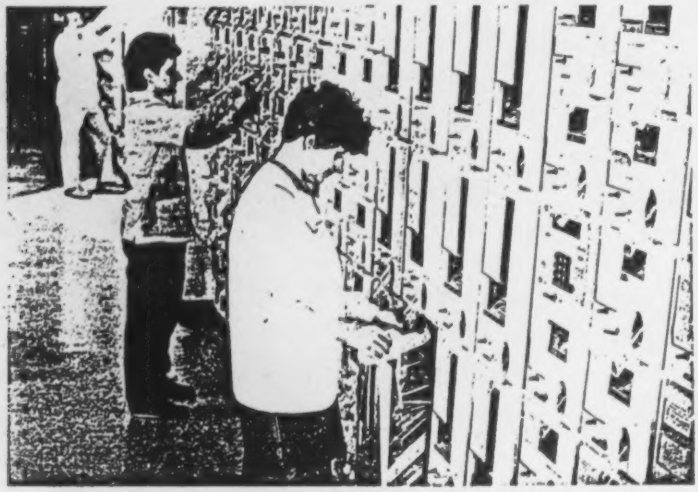


EPS's primary emphasis is on maintenance prescriptions which make up approximately **70% of all prescription dollars spent.** Maintenance drugs not only lend themselves ideally to the home delivery method of distribution, but they also offer the greatest opportunity for substantial savings.

We are confident that by working together as a team, your organization and **Express Pharmacy Services** will achieve cost containment and a significant cost **reduction** in prescription drug expenses.

SPECIFIC SPONSOR SAVING OPPORTUNITIES

Express Pharmacy Services will place you, the sponsor, in control of how and where your prescription dollars are spent and achieve a significant reduction in the cost of health care benefits.



I. NATIONAL ACCOUNT (WHOLESALE) PRICING

Savings will be achieved by identifying your company's volume buying potential and substituting a national account wholesale pricing structure for the retail purchasing environment which has evolved from participants filling all prescriptions at retail stores, since a lower cost alternative was not available. By offering and encouraging the use of **Express Pharmacy Services** for the participant's maintenance drug needs, you channel a significant percentage of all prescription dollars spent, through a single source. The cost benefit from **EPS's** national account (wholesale) pricing structure is based on your overall purchasing volume and the resulting economies of scale realized by **Express Pharmacy Services.** We put you in control of the buying decision and the savings from purchasing on a national account basis may be expected to range from 10%-15% over individual purchases at retail stores.

II. INCREASED GENERIC SUBSTITUTION

A second savings opportunity, is available through **EPS's** dispensing of lower cost FDA approved generic drugs in place of more expensive brand products where legally permitted and authorized by the prescribing physician. By channeling maintenance drug prescriptions through **EPS,** we are in a position to monitor generic substitution opportunities and be sure the sponsor benefits from the use of lower cost generics. Improved control of the prescription drug purchasing decision will result in a higher generic substitution rate and an **additional savings** ranging from 6%-10%.

COUNTING SANITARY TRAY

III. FEWER DISPENSING FEES

Another source of savings available through selection of **Express Pharmacy Services** is a more consistent use of the option to acquire a 90 day supply of prescription drugs, when prescribed, (rather than the more traditional 30 day supply dispensed by retail pharmacies), therefore effectively eliminating most dispensing fees.

Express Pharmacy Services actively encourages 90 day dispensing of maintenance prescription drugs. In addition, stockpiling is prevented through the use of **EPS's** RXTRA computerized monitoring system. The dispensing of larger, more cost effective quantities will result in a savings of 5%-8% compared to the cost of a typical retail prescription.

IV. REDUCED ADMINISTRATIVE EXPENSES

Cost savings may also be realized from reduced administrative expenses as a result of selecting **Express Pharmacy Services** as a centralized source of maintenance prescription drugs.

The sponsor's reconciliation of the billing for prescription purchases is streamlined, as a high percentage of transactions is sourced through a single supplier. In addition, monitoring and control of prescription pricing is facilitated by a standard pricing structure applicable nationwide. Finally, the quantity of claims processed can be reduced by as much as 60% as a result of filling more prescriptions with a 90 day supply. Administrative savings are potentially 2%-3% depending on current program claims processing procedures.

V. MANAGEMENT INFORMATION AND COST CONTROL REPORTS

Another opportunity to reduce and contain your prescription health care costs is through the use of **EPS's** Management Control Reports to monitor and manage the use of the benefit program. Generally, the reports will provide for both active control and passive reinforcement of the cost components of the prescription plan.

Active control leading to the implementation of corrective actions may result from your ability to monitor plan participation and trends. Passive control may be expected to occur as knowledge of the existence of prescription plan monitoring reports becomes known throughout the organization. Although difficult to assess the specific quantitative value of management control reports, **EPS** believes it is reasonable to estimate a 3%-4% savings from cost reduction and long term containment of prescription drug expenses.

PARTICIPANT BENEFITS

The success of **Express Pharmacy Services** in not based solely on cost reduction benefits realized by the sponsor.

Imperative to long term acceptance by participants of the home delivery concept is the need for meaningful and quantifiable benefits.

Therefore, a brief review of the participant benefits is key to appreciating why **Express Pharmacy Services** offers a unique "win-win" means of reducing health care costs and simultaneously retaining participant satisfaction with the benefit.

WHOLESALE PRICING

Just as the sponsor may expect to reduce expenses as a result of benefiting from national account (wholesale) pricing, participants responsible for a percentage of the prescription cost will achieve the same 10%-15% savings.

Participants enrolled in a flat fee co-payment program also benefit indirectly from the sponsor's cost reduction and containment advantages, as increases in the participant's required co-payment are less likely if the sponsor's costs are held in check. Many sponsors have actually shared some of the economies by reducing the co-payment as a result of overall plan savings.

GENERIC SUBSTITUTION

Participants enrolled in a percentage co-payment plan will benefit at the same 6%-10% savings rate as the sponsor. Generic substitution savings also contribute to the retention of the current co-payment policy for flat fee programs.

FEWER DISPENSING FEES

Because elimination of dispensing fees is another overall cost reduction, the participant benefits proportionally on the same basis as the sponsor.

CONVENIENCE BENEFIT

In addition to the quantitative benefits available to participants through the use of **Express Pharmacy Services**, the convenience features of the plan are extremely important. Home delivery of prescription drugs is particularly valued by participants who find it difficult or time consuming to travel to a retail store and wait for their prescriptions to be filled. An important convenience is the ordering of new prescriptions by mail, or phone for refills through the use of an **800** number. Consulting with a Registered Pharmacist by phone, also on an **800** number, is an additional major benefit to all participants.

Overall, participants will value **EPS's** service as a new sponsor provided benefit, and the more frequently it is used, the more savings available to your company and your employees.

SUMMARY

Thrift Drug's **Express Pharmacy Services** offers your company the unique opportunity to take control of the prescription drug purchasing decision and move the current program to a wholesale environment.

The resulting cost reductions and containment benefits will be preserved by monitoring plan activity through the use of **EPS's** Management Control Reports.

Because cost and convenience benefits also accrue to participants, **EPS's** plan will be viewed as an additional benefit, (at no cost to your company), and received enthusiastically by employees.

Express Pharmacy Services commits to working closely with you in a teamwork approach to a common goal of maximizing utilization of the **EPS** service, therefore optimizing available savings.

Comfort is assured from working with a quality service company, a division of JCPenney Company, engaged in the prescription business on a full time basis for over 50 years. Thrift and **EPS** possess the pharmacy experience and customer service sensitivity necessary to successfully provide a quality, cost effective, prescription drug home delivery service.

Express Pharmacy Services will be pleased to offer a comprehensive presentation of services to more fully describe the features and benefits of our quality plan.

AARP PHARMACY SERVICE

Retired Persons Services, Inc.

One Prince Street
Alexandria, Virginia 22314
(703) 684-0244

F. NICHOLAS WILLARD
Director
Governmental Affairs

August 6, 1987

The Honorable Jim Sasser, Chairman
Subcommittee on Government Efficiency,
Federalism and the District of Columbia
U.S. Senate
Room 298 - Russell Senate Office Building
Washington, D. C. 20510

Re: Testimony of Del B. Rowe, Esquire,
Utah Pharmaceutical Association
Subcommittee on Government Efficiency, Federalism
and the District of Columbia, August 5, 1987

Dear Senator Sasser:

Yesterday before your subcommittee, the individual referenced above alleged that the Pharmacy Service of the American Association of Retired Persons (AARP) utilizes an annual AARP federal postage subsidy of $6.5 million to mail Pharmacy Service Catalogs to millions of AARP members. This allegation is not true.

We have attached a copy of a letter we recently transmitted to Congressman Ronnie Flippo to correct the same inaccuracy which had been entered into the hearing record of the Ways and Means Subcommittee on Select Revenue Measures. Our letter was subsequently reprinted in the pharmacy industry press. Nevertheless, representatives of independent retail pharmacists continue to make the same allegation.

We will shortly be submitting a comprehensive statement, supplemented by exhibits, to you for inclusion in the record of the hearing you are currently conducting. In the interim, we hope this letter and the attachment clarify the record regarding Mr. Rowe's inaccurate testimony.

Very truly yours,

Nicholas Willard

F. Nicholas Willard

AARP
PHARMACY
SERVICE

Retired Persons Services, Inc.

One Prince Street
Alexandria, Virginia 22314
(703) 684-0244

F. NICHOLAS WILLARD
Director
Governmental Affairs

June 17, 1987

The Honorable Ronnie G. Flippo
Chairman, Subcommittee on
Select Revenue Measures of
The Committee on Ways and Means
U.S. House of Representatives
2334 Rayburn House Office Building
Washington, D.C. 20515

Re: May 13, 1987 testimony of John Rector, General Counsel and Vice President of Government Affairs for the National Association of Retail Druggists on H.R.1242--The Interstate Sales Tax Collection Act of 1987

Dear Congressman Flippo:

We recently were informed that, on May 13, 1987, John Rector, General Counsel and Vice President of Government Affairs for the National Association of Retail Druggists, testified before your Subcommittee on Select Revenue Measures that the American Association of Retired Persons ("AARP") avails itself of certain federal subsidies and tax exempt privileges in connection with the operation of the AARP Pharmacy Service. Mr. Rector also testified that mail order pharmacy promotions are funded partly through state sales tax exemptions. As we will explain more fully below, much of this testimony of Mr. Rector is inaccurate.

Retired Persons Services, Inc. ("RPS") administers the AARP Pharmacy Service. AARP itself does not sell prescription drugs and therefore is not subject to sales or any other tax on any such transactions. Instead, RPS, which is separately organized and operated as a nonprofit corporation, serves AARP members through the nonprofit AARP pharmacy Service.

RPS is nonprofit in the sense that it has no shareholders and its net income is not and may not be distributed to individuals: net income may be used only in fulfillment of its nonprofit purposes. However, RPS is not exempt from federal or state income tax. RPS pays all federal, state and local taxes where appropriate. RPS does not pay sales tax in jurisdictions in which it has no facilities because under the Commerce Clause of the United States Constitution, the levying of sales tax in such circumstances imposes an unconstitutional burden on interstate commerce. In addition, prescription drugs, no matter by whom dispensed, are exempt from sales tax in 49 states and the District of Columbia. Only in New Mexico, where the AARP Pharmacy Service has no facility, are prescription drugs subject to a gross receipts tax payable by the vendor.

Furthermore, contrary to Mr. Rector's statements, the AARP Pharmacy Service does not avail itself of a federal postage subsidy; all mailings of catalogs, communications with AARP members, and delivery of merchandise purchased by AARP members from the AARP Pharmacy Service are subject to full commercial postage rates or are handled by private carriers such as United Parcel Service, also at commercial rates.

We are hopeful that our remarks serve to correct any misconceptions that Mr. Rector's testimony may have created. Should you have any questions, please feel free to let me know. I will be at your service.

Very truly yours,

F. Nicholas Willard

F. Nicholas Willard

cc: Members of the Subcommittee
Mr. Rob Leonard

American Pharmaceutical Association
2215 Constitution Avenue, NW
Washington, DC 20037
(202) 628-4410
The National Professional Society of Pharmacists
APhA
John F. Schlegel, PharmD
President
D. Stephen Crawford
Chairman of the Board

August 20, 1987

The Honorable Jim Sasser
Chairman
Senate Subcommittee on Governmental Efficiency,
Federalism, and the District of Columbia
432 Senate Hart Office Building
Washington, D.C. 20510

Dear Mr. Chairman:

The American Pharmaceutical Association (APhA) requests that these comments be included in the subcommittee record of the August 5 and 6 hearing on Federal Employees Health Care Coverage and Mail Order Prescription Drugs. APhA commends you for holding those hearings.

APhA is the national professional society of pharmacists, representing the third largest health profession that comprises more than 150,000 pharmacy practitioners, pharmaceutical scientists and pharmacy students. Since its founding in 1852, APhA has been a leader in the professional and scientific advancement of pharmacy and in safeguarding the well-being of the individual patient.

Historically, APhA, and pharmacists generally, have expressed strong opposition to the current practice of mail-order pharmacy. While the current delivery system used by mail order pharmacies may provide a quality product to patients, it cannot provide the vital communication necessary for quality patient service.

The Standards of Practice for the Profession of Pharmacy, jointly set forth by APhA and The American Association of Colleges of Pharmacy (AACP), in the section titled "Patient Care Functions" outline the responsibilities of every pharmacist in any practice setting. These standards, embraced by the entire profession, state that the pharmacist "clarifies patient's understanding of dosage; integrates drug-related with patient-related information; advises patient of potential drug-related conditions; refers patient to other health care resources; monitors and evaluates therapeutic response of patient; reviews and/or seeks additional drug-related information."

These standards were created to protect the individual patients for whom we provide services. Our view of any pharmacy practice setting must be framed by these standards and we encourage our members to adhere to them. While we acknowledge that not all pharmacists in every case will meet the standard, we also contend that many evaluations and functions occur that are not apparent to the average patient. For example, a brief conversation with a patient may reveal slurred speech, indicative of possible overmedication. There is no opportunity for this type of evaluation when pharmacists receive orders through the mail. Also, visual contact with the patient allows the pharmacist to assess apparent comprehension of instructions, and, in general, the patient's physical and mental status.

The provision of leaflets and other printed instructions by mail-order pharmacies does not necessarily constitute communication to a degree that can be considered effective. We cannot assume that the information in the printed material is understood or even read by the patient. There is no opportunity to clarify a patient's understanding of dosage without two-way communication. Patient-related information is only available to a mail order pharmacist when the patient chooses to write that information on the prescription order form mailed to the pharmacy. A mail order pharmacist must assume that the information provided is complete. There is no opportunity to evaluate the patient or environmental factors. While most mail order pharmacy firms provide an 800 phone number, experience indicates that patients have a great deal of difficulty with busy signals and unanswered phones.

While mail-order pharmacies say they provide drug interaction information, the completeness of their patient profiles is dependent upon patient-supplied information. The typical patient on multiple drugs uses one pharmacy as provider. When they are forced to split their purchases between mail-order for chronic medications and community pharmacies for acute medications, neither provider can be assured of knowing the entire drug regimen. Thus, neither provider can provide the quality review and evaluation the patient deserves.

The Standards of Practice encourage the pharmacist to refer patients to other health care resources. Since mail-order pharmacies do not know the resources of the community in which a patient resides, this service is not available. A patient cannot always know when referral is warranted. While a patient's physician is the primary judge of therapeutic response, pharmacists play a key role as the most available source of health information. Patients may unwittingly give up a life-saving service because of decisions made by the purchasers of their health care.

We suggest that there are cost containment opportunities that have not been explored by the Office of Personnel Management in their decision to promote mail-order prescriptions for federal employees. The use of improved drug product selection and drug utilization review are just two of these excellent opportunities to achieve real cost savings without sacrificing quality of care. We would be more than happy to discuss these methods at any time.

Sincerely,

John Schlegel

John F. Schlegel, Pharm.D.
President

JFS/kac

STATEMENT

of

AMERICA'S PHARMACY, INC.

America's Pharmacy, Inc. ("API"), a member of the National Association of Mail Service Pharmacies, has been providing prescription medications to patients nationwide through mail service delivery from its dispensing facility in Iowa since 1963. API is a specialist in furnishing prescription maintenance drugs (those taken over a long period of time for chronic medical conditions) on a mail service basis through programs offered by health insurance carriers, third party administrators, corporate health care benefit plans, unions, health maintenance organizations and other health care benefit plan providers and managers. In addition, API offers its services to organizations, such as foundations, who do not directly provide medical services or health care benefits to their members, but rather which have been formed for the purpose of representing their members and making various desirable benefits available to them.

API is dedicated to providing all patients and sponsoring customers with the highest quality pharmaceuticals and services available. We believe API's long, successful history and experience in providing prescription drugs through mail service delivery, serves as strong evidence of the special benefits to patients and third party payors of mail service pharmacy programs. Accordingly, we appreciate having this opportunity to describe API's programs in order to demonstrate to the subcommittee the high quality level of pharmaceutical services available through use of mail service pharmacies.

API's mail service pharmacy provides patients with the convenience of having prescription medications delivered directly to their homes. This is particularly helpful to many elderly individuals and to others whose mobility is limited or who otherwise have difficulty obtaining access to a pharmacy. API fills most prescriptions on the day of receipt, with the balance filled the next day, and delivers the order via U.S. Mail or United Parcel Service.

While providing the convenience of home delivery service, API also affords patients the opportunity for personal assistance when desired. For patients with questions or concerns, API provides toll-free telephone line service, eleven hours a day, five days a week, and maintains the phone lines open for messages to be left during non-business hours. All questions concerning medication efficacy, drug interactions, dosage, and similar issues are handled by one of API's staff pharmacists. In addition, API dedicates a specific customer service specialist to each sponsoring customer's program, so that patients are able to obtain easily information about the particular pharmacy benefits available to them.

Patients using API's services also get the benefit of API's sophisticated computerized "patient profile" monitoring system. The first time patients send in a prescription, they are asked to submit a form containing information on any allergies, chronic diseases, and particular drug sensitivities. This information then is screened, using an automated data analysis program, against every prescription filled for that individual. The system allows API pharmacists to monitor for potentially adverse drug reactions arising from harmful interactions with previously dispensed medication, or from the patient's allergies or other medical conditions. If, in the professional opinion of the monitoring pharmacist, the possibility of an adverse reaction exists, the pharmacist immediately contacts the prescribing physician to discuss resolution of the problem. API's computer system also enables it to check for potential abuses such as too frequent reordering, duplication of medication prescribed by different physicians, and excessive dosage. These quality controls are supplemented by a verification, for each prescription, of the prescribing physician's Drug Enforcement Administration ("DEA") number. This is done by a check against an on-line data file of physician names, addresses, and DEA numbers and, if necessary, the American Medical Directory, which lists all physicians residing in the United States.

All prescriptions filled by API are reviewed by three different registered pharmacists at three separate stages of the process. Once a prescription has been initially reviewed by one of API's pharmacists and cleared through the patient profile monitoring system, a second pharmacist is responsible for filling the order. Where appropriate, the physician's prescription orders are supplemented by cautionary labels and other information concerning the medication, which are generated automatically by API's computer system. Finally, to ensure that each order has been filled accurately, a quality assurance review of the prescription and drug actually dispensed is performed by a third pharmacist. An additional check of the entire order is done by a pharmacy technician in API's shipping area.

API also assures quality service through its strict inventory controls. Immediately upon receipt of all new inventory, an API technician checks the products received against the package invoice. Each product is checked individually for appropriate amount, strength, and drug code number. The technician also checks for possible damage and the expiration date. Normally, drugs are not accepted if the expiration date is within six months of delivery to API. Additionally, all inventory is re-examined every month, and labels are affixed to each drug product which has an expiration date of within six months, to ensure that no outdated products will be dispensed. API's dispensing area is secured, and only pharmacists and pharmacy technicians are allowed in this area.

In addition to the customer service and quality assurance benefits of API's mail service pharmacy programs, API offers patients and sponsoring customers the significant advantage of comparatively low cost. The level of its business enables API to purchase drug ingredients at high volume discounts and to develop operational efficiencies that minimize its administrative and dispensing costs. Additionally, API encourages use of cost-effective generic medications recognized by the FDA as therapeutically equivalent, where API also has assured itself that the bioequivalence and bioavailability of the generic product is acceptable. The savings generated by these features of API's mail service pharmacy programs result in substantial cost advantages for its patients and customers.

Like any other pharmacy, API is licensed in the state where its dispensing facility is located--which is Iowa--as are all its pharmacists. API's pharmacy operations are fully regulated by the Iowa Board of Pharmacy, and API complies fully with all applicable federal and Iowa state law. Thus, with respect to regulatory standards governing facility inspections, personnel qualifications, record-keeping, responses to customers, and other safety and quality assurance matters, mail service pharmacies such as API are subject to and, at minimum, meet the same requirements as any other appropriately licensed pharmacy. API's pharmacy operations, as described above, generally exceed these standard requirements.

We are submitting this statement in the belief that its summary description of API's pharmacy operations and of the very real medical and financial benefits API offers to patients and third party payors, provides substantial evidence of the safety, quality, and usefulness of mail service pharmacy in the United States. API sincerely hopes that its testimony has furnished useful information to subcommittee members and has demonstrated the important and desirable role mail service pharmacy can play in this nation's health care system.

July 31, 1987

Senate Subcommittee on Government Efficiency
Federalism and District of Columbia
432 Hart Senate Office Building
Washington, D. C. 20510

Statement for Record: Wednesday, August 5, 1987--2:30 p.m.

To Whom It May Concern:

I am a registered Pharmacist currently employed at Giant Pharmacy, 2868 Virginia Beach Boulevard, Virginia Beach, Virginia.

On or about January 1, 1987, I was approached by Mrs. Winifred Owens concerning a prescription she had received from National Prescription Services in Tampa, Florida. Both Mr. Bert Owens and Mrs. Winifred Owens were regular customers at the Pharmacy for the four years I have been there. Mrs. Owens had sent her prescription for Corgard 80 mg to the National Prescription Service in Florida due to the fact that her husband's Blue Cross/Blue Shield Policy under the Federal Employees Health Benefit Program allowed her to receive a 90 day supply of medication for a small copayment. Mrs. Owens and her husband presented to me the prescription she received in the mail expressing concern because the medication she received was a small pink tablet. Since Mrs. Owens had been taking Corgard 80 mg for hypertension for an extended period of time, she was familiar with the appearance of Corgard as a large light blue tablet. The discrepency in appearance led Mrs. Owens to question the drug she had received wondering if it was a generic for Corgard or another drug. I informed Mrs. Owens there was not a generic substitute for Corgard available and upon examining the medication, I was surprised to see she had gotten Coumadin(an anticoagulant) 5 mg tablet and an amount of 90. The medication was clearly Coumadin since the tablet was imprinted with Coumadin 5 on one side of the tablet and DuPont imprinted on the other side of the tablet. The bottle containing Coumadin was labeled Corgard 80 mg #90, with the direction to take one tablet daily, also clearly legible under the prescription label was a prepack label which labeled the container cyrstelline warfarin sodium. Mrs. Owens asked me what would have happened if she had taken this medication and without going into specifics, I informed her that it could have been life threatening.

Having been a parmacist for 10 years, I am aware that under stressful situations mistakes can be made in the filling of prescriptions and any pharmacist who says he or she has not filled a prescription incorrectly is lying. On the other hand, certain medications automatically bring to mind the inherent possibilities of injury if the incorrect medication is dispensed so that extra care should be used as in this case. I am sure that in these mail order operations that an assembly line type dispensing procedure is used and usually the prescriptions are filled by technicians and the pharmacists check the medication and directions for use but still there must be some control procedures in these operations. In this particular incident, a negligence suit could have easily occurred.

Mrs. Owens' response when I informed her that she had received the wrong medication was one of shock and horror. Having explained to her that Coumadin was an anticoagulant which inhibited the normal process of blood clotting, she wondered what if she had been given a new medication she was not familiar with its appearance and had taken it or what if she like many individuals just take the medication they receive with regard to appearance or if an elderly person with eye problems could not distinguish appearances in the differences in medication, that the severity of this error is magnified. Mrs. Owens informed me that from now on she would get her medication at my pharmacy rather than trust an unknown pharmacist in Florida no matter what her BC/BS policy recommended or required.

Mrs. Owens asked what actions she should take concerning this matter. I advised her to correspond this problem to the National Prescription Services, The Virginia Board of Pharmacy, and Florida Board of Pharmacy, and Blue Cross and Blue Shield. On February 25, 1987. Mr. Owens showed me a copy of the letter she was sending to the above mentioned parties concerning this matter. Also she said she sent a copy to our Congressional Representative, The Honorable Owen Pickett.

Mr. Owens later brought to me the letter they received from Congressman Pickett received on March 5, 1987. He stated receipt of her letter and his assistance in this matter by contacting officials of the Office of Personnel Management which has jurisdiction over Federal Employees Health and Benefit Program. She also received a letter on March 15, 1987 from the Virginia Department of Health Regulatory Board stating receipt of complaint filed with the Board of Pharmacy of Virginia and that the matter did not fall within the Board's jurisdiction, but the complaint was forwarded by the Board of Pharmacy of Virginia to the Board of Pharmacy of Florida.

Mrs. Owens later received letters from the Board of Pharmacy of Florida and National Prescription Services stating the problem was being taken care of.

To the best of my knowledge, she did not receive any later correspondence on the matter until she and I were contacted by the Senate Subcommittee Representatives.

Without going into great detail, Coumadin interferes with the synthesis of Vitamin K--dependent clotting factors--thus depleting the body of certain clotting factors. In the case of Mrs. Owens, two problems would occur. Her blood pressure would increase due to her lack of Corgard and taking Coumadin in its place would greatly diminish her body's normal blood clotting capacity where the principal adverse effect would be hemorrhage. Without her knowledge of Coumadin effects and the strict precautions which accompany the administration of this drug, the result could be life threatening. Just imagine the problems incurred with such a drug causing significant gastrointestinal or urinary tract bleeding or the simple cutting of a finger, a vist to the dentist to pull a tooth or cleaning, or a surgical procedure.

It also must be considered the many drug interactions which occur that increase the anticoagulant effects of Coumadin. Many simple over the counter medications such as aspirin increase Coumadin effect. At the time Mrs. Owens received this medication she was taking Equagesic which contains aspirin; an antibiotic Erythromycin which enhances the anticoagulant effect, and a cough medi-ation, Tussionex which enhances the anticoagulant effect. Also it is noted that enhanced anticoagulant effects are seen in females being more sensitive to these agents.

Page 3

I cannot overemphasize the gravity of this mistake. As stated before, too many individuals are taking medication without making sure its appearance is the same as previously taken. The individuals are trusting that the medication is correct, or elderly individuals' inability to make sure it is correct. In an operation where there are no checks and balances, the consequences of an individual attempting to save money for themselves or an insurance carrier, the results can be monumental when a life is lost.

Respectfully,

Theron C Cash III

Theron C. Cash, III, R.Ph.
2936 Bray Road
Virginia Beach, Virginia 23452
804-486-1217 (home)

TCC/lwc

pmsi®
PHARMACY MANAGEMENT SERVICES, INC.
4224 Henderson Boulevard ☐ P.O. Box 320178
Tampa, Florida 33679 ☐ (813) 254-7676
1-800-237-7676 (Continental U.S.A.)
1-800-282-7676 (Florida only)

August 3, 1987

Federal Express

The Honorable Jim Sasser
298 Russell Senate Office Bldg.
Washington, DC 20510

Re: PMSI Mail Service Pharmacy

Dear Senator Sasser:

In response to the list of questions attached to your recent letter to the National Association of Mail Service Pharmacies (of which we are a member), the following information and procedures pertain to Pharmacy Management Services, Inc.:

(1) PMSI is a full-service health care company providing drugs, medical supplies and medical equipment for the catastrophically injured patient. Pharmaceuticals represent less than 50% of the total orders processed. PMSI does not impose a quota system on its pharmacists, and maintains a ratio of less than 100 prescriptions per pharmacist per working day.

(2) and (3) The following policies and procedures outline PMSI's considerations of safety and recordkeeping.

POLICIES AND PROCEDURES
FOR PMSI PHARMACY OPERATION

Receipt, Processing and Dispensing:

Each day incoming mail is separated into orders pertaining to medication, medical supplies, medical equipment, TENS units, and TENS supplies. These orders are then delivered to those departments. The departments then, in turn, pull the patient file jacket which contains all the necessary information which we require in processing our orders, such as:

1) Patient's name, address and phone number
2) Carrier file number
3) Date of accident
4) Social security number
5) Diagnosis
6) Insurance carrier address and city
7) Responsible adjuster
8) Authorized physicians' names, addresses, phone numbers, DEA numbers

9) Attorney, if appropriate
10) Type of case in which the claimant falls, whether it be medical, equipment, TENS or supplies

After the file has been pulled and the prescriptions/orders have been matched, the customer service clerk transcribes the order onto 3-part order form, which is universal to all departments. Each form has a control number, and the three copies are disseminated as follows:

(1) One copy is maintained in the patient jacket;
(2) One copy goes to shipping; and
(3) One copy follows the order to the claimant.

From Customer Service, the complete jacket, containing original prescriptions, orders and order form, is then sent to a checking station where these procedures are followed:

1) If it is a prescription request, the new prescription is entered into a computer terminal so that it can be checked against any drug-drug reaction which could occur within the patient's prescription profile. Should an interaction be present, a printout of the interaction is generated and passed along to the pharmacist for proper evaluation.

2) The prescription is checked against diagnosis for compensability, if compensability is not so indicated by the physician on the original prescription. If there is a question as to compensability, the physician's office is called to verify same.

3) The prescription is checked to ascertain that the prescribing physician is authorized by the insurance company to treat the claimant. If our records do not indicate the physician is authorized, the adjuster on the file is contacted to verify same. Should the adjuster not authorize the physician, the claimant is notified that the insurance company will not reimburse for the prescription(s), and he/she will have sole responsibility for payment.

4) Prescriptions are checked to prevent premature refills according to doctors' prescribed directions.

From this point, the complete patient jacket containing the prescription and the order are passed to a pharmacist for his/her review to check that the prescription has been properly transcribed to the order form. Here the pharmacist also checks the prescription to insure that it is written up properly with the patient's name, the doctor's name, the date, correct directions of use, generic drug name (if applicable), and drug strength and quantity. The order is initialled by the reviewing pharmacist at this point.

The pharmacist then turns the complete jacket to a computer input operator. This person enters the necessary information into the computer to produce a prescription label. The prescription label is then attached to the order form and is sent to the pharmacy for filling. The prescription is filled and checked again by a pharmacist to assure that the prescription label is correct according to the order (and in accordance with the same criteria outlined in the previous paragraph). Appropriate auxiliary labels are added, and the order moves on for packing and shipping.

The reviewing pharmacist at this point also initials the order. Part 1 of the three-part order form is maintained in the patient's jacket for an historical record, along with the original prescription; Part 2 is maintained in shipping for easy cross reference by serial number; and Part 3 is a packing slip which is shipped out along with the order.

The control number on the order form is entered into the shipping manifest system so that a daily record is produced for proof of shipment. All orders to ship beyond a 500-mile radius of Tampa, Florida are sent via UPS Blue Label (2nd Day Air).

Prescriptions Requiring Special Handling

Class III, IV and V controlled substances are stamped with a red "C" stamp. A computer report at the end of the day listing all Class III drugs is generated with date, prescription number, patient's name, physician's name, address and DEA number. This report is reviewed and signed by a pharmacist at the end of the day.

Class II drugs are handled in the same manner as Class III drugs in the preceding paragraph, with the exception that:

(1) the prescription is cancelled by the first reviewing pharmacist by his/her signature and license number on the face of the prescription; and

(2) an extra prescription label is generated by the computer to be attached to the order form and signed by the dispensing pharmacist.

Inventory Control

All Schedule II drugs are immediately entered when received into our computer inventory control system, and are deducted at the time of processing for filling, thereby providing a perpetual inventory.

Professional Consultation

Professional pharmaceutical consultation with our pharmacists is available to all patients and health professionals.

Refill Prescriptions

At the end of each day, the computer prints out a report to notify physicians when the last refill has been dispensed. This form is forwarded to the physician for his/her records, and if the listed medication is to be continued, he/she signs the authorization and returns it to our pharmacy.

- PMSI does not repackage any pharmaceuticals prior to dispensing.
- Should a drug have a recall, PMSI can instantly obtain a list names, addresses and telephone numbers of the prescribing physicians and the patients to whom the drug has been dispensed. This list will also show the last date the drug was dispensed to each patient.

(4) PMSI follows the appropriate laws and regulations of the state in which it resides.

Senator Sasser, I hope the above information highlights the cost effectiveness and service-oriented emphasis, not only of PMSI, but also of the other major mail service pharmacies represented at your Subcommittee's current hearings.

Sincerely yours,
PHARMACY MANAGEMENT SERVICES, INC.

Cecil S. Harrell

Cecil Stanford Harrell
President

CSH/lgb
Enclosures

A National Program of Medical Cost Containment For The Insurance Industry

pmsi

Since 1976, PMSI has been helping to manage medical costs associated with catastrophically injured, long term disability cases, while simultaneously raising the levels of safeguards to the health of the injured party. The following are some of the methods we have developed to accomplish these goals.

Prescriptions received by our registered pharmacists are reviewed and entered into our IBM System 36 computer.

Cost Control ▸	— Screening process identifies those drugs (and medical supplies) that are not related to the compensable injury
Safeguard & Cost Control ▸	— Duplicated prescriptions are intercepted, e.g., in those cases where two physicians prescribe the same or similar drugs
Safeguard & Cost Control ▸	— Excessive dosages are prevented, e.g., we will decline to refill prematurely a prescription which authorizes a refill
Safeguard & Cost Control ▸	— Attending physician(s) are alerted to potentially adverse drug-drug interactions *Our computer is programmed to scan automatically the patient's complete drug-taking profile and to identify contra-indications for any combinations of drugs entered*

After these procedures have been completed and the prescriptions filled:

Convenience & Cost Control ▸	— Drugs are then vacuum sealed and, with needed medical supplies, shipped via UPS directly to the injured person's home *(mileage charges eliminated)*
Cost Control ▸	— The delivery schedule of supplies, sent directly to the claimant's doorstep, is designed to insure that home inventory is always adequate, but never too great *Over-supply can result in loss through spoilage and also by tying up funds in inventory that is not being used*
Cost Control ▸	— Because PMSI serves hundreds of carrier offices throughout the United States, our purchasing power permits us to share volume discounts
Cost Control ▸	— PMSI bills each carrier office by file on a monthly basis. This bill covers the total list of drugs and supplies delivered to the referenced claimant. As a result of this comprehensive monthly accounting, the carrier need write only a single check per file
Cost Control ▸	— Generic equivalents are provided in appropriate instances
Cost Control ▸	— Each branch office receives from us a monthly Savings Analysis report which summarizes actual savings on all items with an established national retail price. Regional and national offices receive a corporate summary report

Q. Are all drugs and supplies shipped from Tampa?	**A.** Yes. Home delivery service is by UPS (except in those rare cases when UPS does not deliver to a particular locale. Then we use the U.S. Postal Service)
Q. Doesn't this long distance delivery system create a problem? Isn't this an inconvenience for the claimant?	**A.** No. On the contrary, having drugs and supplies delivered to the claimant's doorstep saves time and money, and because the need for each of these items — drugs and/or supplies — is normally always known well in advance, a timely delivery schedule can be confidentially established. (We do, of course, provide for unusual circumstances. In emergency situations, the claimant is told to purchase the items needed locally and have the bill sent directly to PMSI.)
Q. Is your service available nationwide?	**A.** Yes. We have cases from Maine to California
Q. Do you place restrictions on the type of cases which you will agree to service?	**A.** No. Significant savings occur, however, only when the average total monthly expenditure on drugs, supplies and durable medical equipment reaches at least $50.
Q. When do we refer a case to you?	**A.** Patients may be referred while still in the hospital or immediately following an injury. Others could be referred months or even years after the date of their disablement
Q. Can I order equipment on a one-time/as-needed basis?	**A.** Yes. (Exercise bicycles, whirlpool baths, wheelchairs, etc.)

Call toll free today!

1-800-282-7676 (Florida Only)
1-800-237-7676 (Continental U.S.A.)

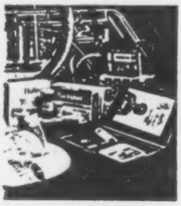
pmsi™

PHARMACY MANAGEMENT SERVICES, INC.

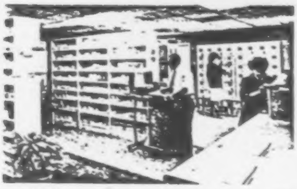
PMSI provides everything that is needed by the [illegible] individual except the [illegible] prosthesis

Welcome To PMSI... The Fast, Easy Way To Get Just What Your Doctor Ordered.

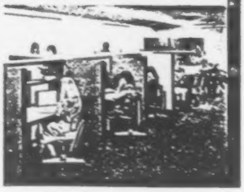
DEVERY
pmsi
pmsi®
Health Care Services That Focus On You.



Orders are filled directly from PMSI's large warehouse of medical supplies and equipment. All items are carefully packed, and shipped quickly.



are taken by specially trained operators, and passed ediately to licensed pharmacists who check and fill each prescription.



Meet PMSI...The Health Care Company Built For You.

Since its start in 1976, PMSI has become the nation's leading supplier of direct-to-home medications, medical supplies, TENS units and durable medical equipment. The reasons that patients like PMSI so much are simple —

Easy Ordering

Whenever you need medications, medical supplies or equipment for your covered injury/illness, just pick up the telephone and tell us what you need. The call is FREE. And you can call at YOUR convenience. Our highly trained staff is waiting to help you.

Just What Your Doctor Ordered

Licensed pharmacists use high-tech dispensing systems to provide medications exactly as your doctor prescribes. And our medical supply warehouse maintains a large and complete inventory so that we can fill your orders right...and fill them fast.

Every order is completed, packaged and shipped to you via UPS to arrive promptly at your door.

No Cost To You

Best of all, the bill goes directly to your insurance company, so you never have to pay money out of your pocket.

Here's Your Ticket to PMSI Convenience

You are already approved to receive all these PMSI advantages. Just keep this PMSI card in a safe, handy place. Tell us your PMSI ID number when you call to place your order. Then relax. We'll fill your order, deliver it to you, and bill the insurance company.

Welcome to PMSI!

Call Toll-Free: **1-800-237-7676** (Continental U.S.A.)
1-800-282-7676 (Within Florida)

pmsi

Pharmacy Management Services, Inc.
4224 Henderson Boulevard
P.O. Box 320178, Tampa, FL 33679

T.E.N.S. PRICE REDUCTION!

pmsi®

Pharmacy Management Services, Inc.
P.O. Box 320178 • Tampa, FL 33679

BULK RATE
U.S. POSTAGE
PAID
Tampa, FL 33679
Permit No. 3884

T.E.N.S. PRICE REDUCTION!

TENS-TRAC

Brings Down The High Cost Of T.E.N.S.

Control T.E.N.S. Usage And Contain Costs With TENS-TRAC From PMSI.

Savings begin when you purchase a new T.E.N.S. unit at PMSI's low, discounted price. Then every time that you use our TENS-TRAC retrieval and recycling program, these savings increase. The more claimants who use the unit, the lower the cost.

Here's how it works.

Purchase a new T.E.N.S. unit from PMSI for only $465 and we ship it directly to your claimant. Through careful monitoring of reorder information, TENS-TRAC lets us know when that unit is no longer in use. The unit is then retrieved, refurbished and stored in your company 'bank.' Upon request ***from any of your branch offices nationwide,*** this unit is recycled to the next claimant who needs it. The one-time handling charge for this 24-hour delivery is only $30.

Or ***rent*** a unit for ***$50 per month*** — up to two months' rent can be applied to the purchase price.

Here is the way that the real cost of a T.E.N.S. unit is reduced by recycling:

Times Recycled	~~0~~	~~1~~	[illegible]	~~3~~	~~4~~
Cost per User	~~*$540~~	~~*$285~~	~~*$[illegible]00~~	~~*$158~~	~~*$132~~

New Low Pricing

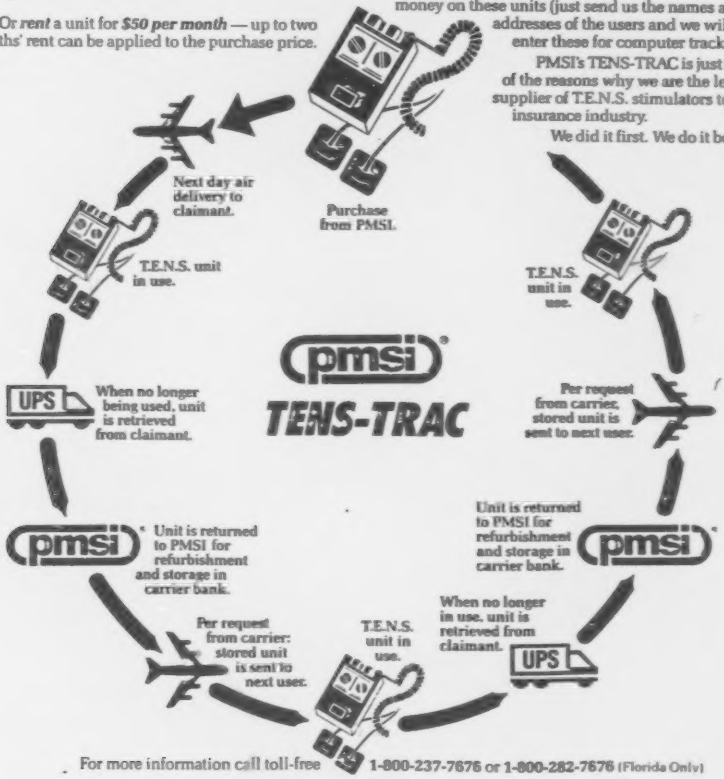
Times Recycled	0	1	2	3	4
Cost per User	*$465	*$248	*$175	*$139	*$117

(*Immediate savings will vary according to brand of unit purchased.)

Quite simply, the more times a T.E.N.S. is recycled, the lower the cost. Even if you have purchased some of your T.E.N.S. elsewhere, TENS-TRAC can immediately commence to save you money on these units (just send us the names and addresses of the users and we will enter these for computer tracking).

PMSI's TENS-TRAC is just one of the reasons why we are the leading supplier of T.E.N.S. stimulators to the insurance industry.

We did it first. We do it best!


Next day air delivery to claimant.
Purchase from PMSI.
T.E.N.S. unit in use.
T.E.N.S. unit in use.
UPS
When no longer being used, unit is retrieved from claimant.
pmsi
TENS-TRAC
Per request from carrier, stored unit is sent to next user.
pmsi
Unit is returned to PMSI for refurbishment and storage in carrier bank.
Unit is returned to PMSI for refurbishment and storage in carrier bank.
pmsi
When no longer in use, unit is retrieved from claimant.
UPS
T.E.N.S. unit in use.
Per request from carrier: stored unit is sent to next user.

For more information call toll-free 1-800-237-7676 or 1-800-282-7676 (Florida Only)

ATTENTION:

WORKERS' COMPENSATION SUPERVISORS, NURSES AND ADJUSTERS.

Let us give you a second opinion.

We can save you money on durable medical equipment.

When doctors specify any item of durable medical equipment for your claimants, why not call PMSI for a price quotation and delivery date. PMSI buys, direct from the manufacturers, all types of health care equipment such as wheelchairs, hospital beds, whirlpool baths, trapezes, exercise bicycles — everything needed in the treatment of employment-related injury.

PMSI services over 1500 carrier offices nationwide, allowing us to pass significant savings on to you with our volume discount purchasing, because there are no middlemen involved.

As an added convenience, PMSI provides you with a once-monthly, itemized invoice. You will also receive a quarterly report which summarizes the savings on all items purchased from PMSI; and these savings will be identified on a per file basis.

Let our ten years of experience pay off for you! For any of your durable medical equipment requirements, call our Medical Equipment Department today.

1-800-237-7676 (Continental USA)
1-800-282-7676 (Within Florida Only)

pmsi®

Pharmacy Management Services, Inc.
P.O. Box 320178 • Tampa, FL 33679

This report is sent to claim representatives whenever PMSI "intercepts" a prescription, in order to keep the carrier informed of additional cost savings achieved through our not dispensing inappropriate orders.

PHARMACY MANAGEMENT SERVICES, INC.
4224 Henderson Boulevard ☐ P. O. Box 320176
Tampa, Florida 33679 ☐ (813) 254-7676
1-800-237-7676 (Continental U.S.A.)
1-800-282-7676 (Florida only)

MED-TRAK™ SAVINGS REPORT

TO:

CARRIER:

ADDRESS:

RE: ____________________

File # ____________________

On __________, an inappropriate prescription for this patient was intercepted by the PMSI Med-Trak™ system for the following reason:

____ Unauthorized physician	____ Excessive dosage/early refill
____ Unrelated to compensable injury	____ Duplication of drug already prescribed
____ Generic alternative substituted	____ Adverse drug-to-drug interaction would have resulted

____ Other: ______________________________

Date of Last Refill	Drugs Involved	Quantity		
			Dr.	
			Dr.	
			Dr.	

This action is estimated to have saved $ __________ in direct claim costs, which translates into an annualized savings of $ __________.

PMSI is continuing to monitor the medications on this difficult-to-manage case.

PMSI Rep: ____________________ Date Mailed: ____________________

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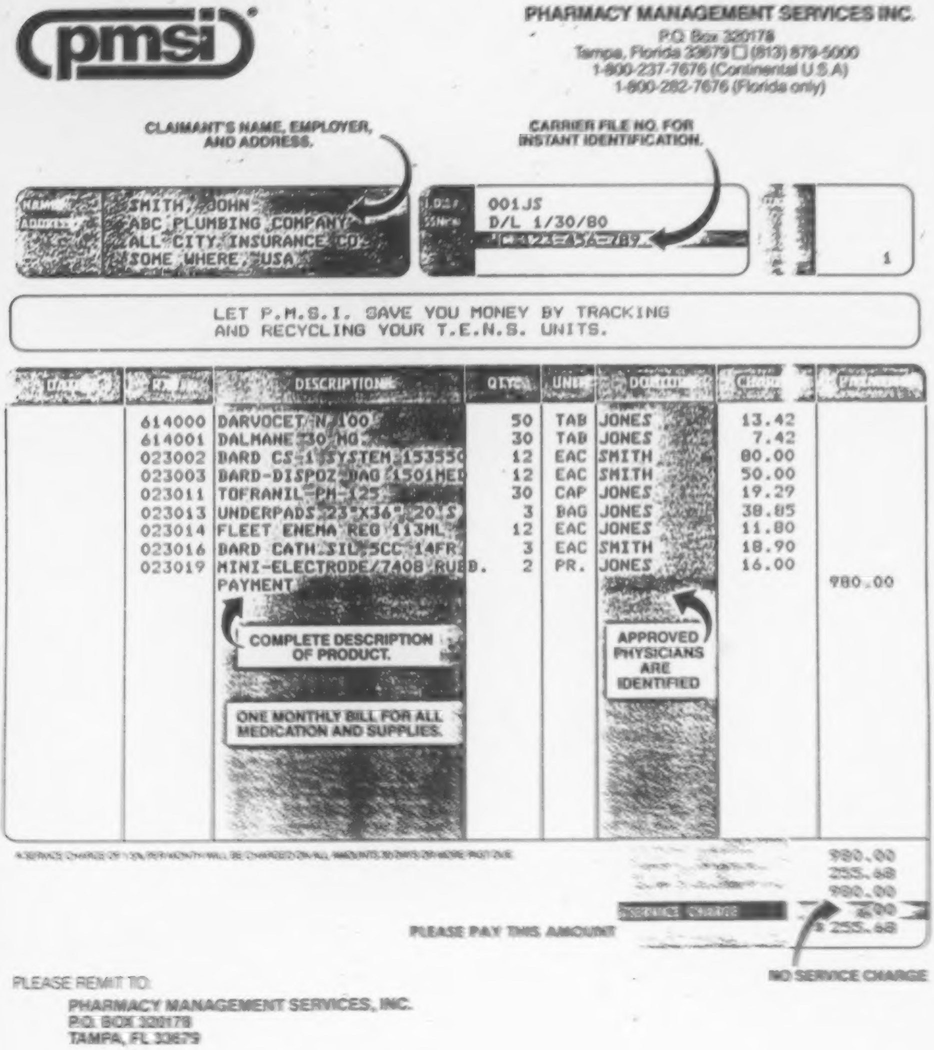
4224 Henderson Boulevard ☐ P.O. Box 320178
Tampa, Florida 33679 ☐ (813) 254-7676
1-800-237-7676 (Continental U.S.A.)
1-800-282-7676 (Florida only)

PMSI'S PRICES VS. SUGGESTED RETAIL ON COMMONLY-USED MEDICAL SUPPLIES

	Suggested Retail	PMSI's Price	Savings	Percent Saved
American Pharmaseal Aqua-K Pad	$ 139.80	$ 92.00	$ 47.80	34.2%
Dazey Whirlpool Bath #3666	440.00	299.00	141.00	32.0%
E&J Shower Rehab. Chair	797.00	677.45	119.55	15.0%
Lumex Commode Chair #6437	180.00	162.00	18.00	10.0%
Motion Designs Quickie II Wheelchair	1,405.00	1,194.25	210.75	15.0%
Roho Cushion #1R89	265.00	230.00	35.00	13.2%
FuturoWalker, Folding Adjustable	70.00	54.95	15.05	21.5%
Squibb Duo-Derm 4x4 5's	25.95	19.53	6.42	24.7%
American Pharmaseal Latex Gloves Large, 100's	27.40	13.95	13.45	49.0%
Chesebrough-Ponds Uri-Drain 144s/7323	144.00	110.63	33.37	23.2%
Inmed Ultrasil Catheters 24-5	12.50	6.25	6.25	50.0%
Mentor Catheters 14 FR 50's/450	37.15	32.00	5.15	13.9%
Urocare Leg Bag Lg #7532LT	4.50	3.75	.75	16.7%
Bard Touchless Cath Kit 4A2045 50's	264.50	202.53	61.97	23.4%
Davol Catheters 14 FR 100's	124.00	86.00	38.00	30.6%
J&J Dermilite 2" 6/5117	17.93	12.93	5.00	27.9%
Jobst Supp Hose Mens Medium	7.95	7.16	.79	9.9%
Argyle Robnel Catheter 14 FR 100/492041	87.00	63.33	23.67	27.2%
Empi 984 TENS Unit	660.00	465.00	195.00	30.0%

4/87
prices.med



PHARMACY MANAGEMENT SERVICES INC.

P.O. Box 320178
Tampa, Florida 33679 ☐ (813) 879-5000
1-800-237-7676 (Continental U.S.A)
1-800-282-7676 (Florida only)

CLAIMANT'S NAME, EMPLOYER, AND ADDRESS.

CARRIER FILE NO. FOR INSTANT IDENTIFICATION.

NAME
ADDRESS
SMITH, JOHN
ABC PLUMBING COMPANY
ALL CITY INSURANCE CO
SOME WHERE, USA

I.D.#
SS No.
001JS
D/L 1/30/80
C-123-456-789

1

LET P.M.S.I. SAVE YOU MONEY BY TRACKING
AND RECYCLING YOUR T.E.N.S. UNITS.

DATE	RX NO.	DESCRIPTION	QTY.	UNIT	DOCTOR	CHARGE	PAYMENT
	614000	DARVOCET N 100	50	TAB	JONES	13.42	
	614001	DALMANE 30 MG.	30	TAB	JONES	7.42	
	023002	BARD CS-1 SYSTEM 153550	12	EAC	SMITH	80.00	
	023003	BARD-DISPOZ BAG 1501MED	12	EAC	SMITH	50.00	
	023011	TOFRANIL-PM-125	30	CAP	JONES	19.29	
	023013	UNDERPADS 23"X36" 20'S	3	BAG	JONES	38.85	
	023014	FLEET ENEMA REG 113ML	12	EAC	JONES	11.80	
	023016	BARD CATH.SIL 5CC 14FR	3	EAC	SMITH	18.90	
	023019	MINI-ELECTRODE/7408 RUBD.	2	PR.	JONES	16.00	
		PAYMENT					980.00

COMPLETE DESCRIPTION OF PRODUCT.

ONE MONTHLY BILL FOR ALL MEDICATION AND SUPPLIES.

APPROVED PHYSICIANS ARE IDENTIFIED

[illegible]	980.00
[illegible]	255.68
[illegible]	980.00
SERVICE CHARGE	.00
PLEASE PAY THIS AMOUNT	$ 255.68

NO SERVICE CHARGE

PLEASE REMIT TO:

PHARMACY MANAGEMENT SERVICES, INC.
P.O. BOX 320178
TAMPA, FL 33679

P.M.S.I. can help you contain costs related to your P.T.'s and T.T.'s.

Your long term catastrophic injury cases — the ones that require month in-month out attention — are historically the hardest to monitor. Cases of this kind demand detailed management and they very often result in unwarranted costs to the carrier.

P.M.S.I. has developed a program of controls that relieves you of many of the time consuming tasks associated with administering medical services to your disabled claimants.

Our pharmacists screen every supply order and every prescription. Using custom-designed computer programs, backed up by manual tracing procedures, we deliver only those supplies and drugs that are authorized and that relate to the compensible injury. Our pharmacists also review all prescriptions for potential adverse drug-drug reaction, duplications and/or excessive dosage.

Once a month, you receive a single detailed statement from us instead of sporadic imprecisely defined bills from multiple vendors — or even from the patient himself.

All drugs and supplies are shipped by U.P.S. to the claimants' doorstep. These drugs are vacuum seal-packed. This service is not only a great convenience to the patient and his family but it also eliminates mileage reimbursement costs and delivery charges.

Since 1976 the P.M.S.I. program has proved itself to be cost effective and, as a result, is now being used by several hundred major insurance offices nationwide.

If you should want any additional information, please call:

(813) 879-5000
1-800-237-7676 (Continental U.S.A.)
1-800-282-7676 (Florida Only)

pmsi®

PHARMACY MANAGEMENT SERVICES, INC.
4224 Henderson Boulevard ☐ P.O. Box 320178
Tampa, Florida 33679 ☐ (813) 254-7676
1-800-237-7676 (Continental U.S.A.)
1-800-282-7676 (Florida only)

PMSI's PRICE FOR ANY OF THE FOLLOWING TENS UNITS IS

* * * * * * $465.00 * * * * * *

Model	Manufacturer	Manuf. Sugg. Retail Price	PMSI Price
Agar 8000	Agar Electronics	$560.00	$465.00
AutoTens V	Physiotronics	625.00	465.00
Biomod	T.E.N.S., Inc.	595.00	465.00
Biomod 5	T.E.N.S., Inc.	650.00	465.00
Comfort Burst	Medtronics	595.00	465.00
Comfort Wave	Medtronics	630.00	465.00
Dynex II	LaJolla Technology	595.00	465.00
Empi 982 H	Empi, Inc.	660.00	465.00
Empi 984	Empi, Inc.	685.00	465.00
Jobstens II	Jobst	550.00	465.00
Maxima	Staodynamics	645.00	465.00
Mentor 100	Mentor, Inc.	580.00	465.00
Mentor 150	Mentor, Inc.	590.00	465.00
Mentor 250	Mentor, Inc.	625.00	465.00
Mentor 259	Mentor, Inc.	625.00	465.00
Ministim I	Medical Designs	595.00	465.00
Ministim II	Medical Designs	625.00	465.00
Omni	Physio-Technology	595.00	465.00
Orion	Neuromedics/Henley Internt'l.	630.00	465.00
Pulsar	Cryomedics	550.00	465.00
Spec II SX	Medical Devices	645.00	465.00
Staodyn 4500	Staodynamics	595.00	465.00
Staodyn 4500B	Staodynamics	595.00	465.00
Staodyn 4500M	Staodynamics	625.00	465.00
Stimburst	Stimtech	620.00	465.00
Stimset	Stimtech	520.00	465.00
Tenzcare 6242	3M Medical Products Division	625.00	465.00
Ultra II SX	Medical Devices	645.00	465.00

MUSCLE STIMULATORS AVAILABLE (various prices)

EMS-I & EMSPlus	Staodyn
Myocare	3M Medical Products Division
Neuragar IV	Agar
Neuromuscular II	Mentor
Quadriflex	Medtronics
Respond II	Medtronics
Soken 1, 2 & 3	Rehab. Medical Specialities (RMS)
710 NMS	Empi, Inc.

4/87

PMSI PRICES VS. SUGGESTED RETAIL ON MOST-USED TENS SUPPLIES

Description	Retail	PMSI Price	Discount
9 Volt Battery Charger	$25.00	$ 9.00	64%
Carbon silicone rubber electrode - 1 pair	12.00	4.86	60%
Pre-gel snap disposable electrode - 60/pouch	45.00	35.00	22%
Conductivity Gel 3 oz.	2.85	1.50	48%
Transpore tape patches/100's	18.00	12.95	28%
Micropore tape patches, 100's, 3x3	17.00	11.00	35%
Skin prep wipes, 50's	12.50	9.15	27%
Uni-solve wipes, 50's	12.50	8.88	29%
2" round snap carbon silicone electrode	11.25	6.98	38%
2x4" carbon electrodes - 1 pair	11.95	9.90	17%
Karaya pad -pouch of 60 reusable	44.00	35.00	20%
Staodyne -Staoderm III electrodes	35.00	31.00	12%
3M Tenzcare electrodes 4/pkg	18.45	16.95	9%
Nicad battery 9 volt	15.00	10.00	33%
Nicad battery AA size	5.00	3.90	22%
Nicad battery AAA size	5.00	3.90	22%
Nicad battery N size	5.00	3.90	22%
The Protector electrode 40/pkg	60.00	32.00	47%

supplies.lst
4/87

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PHARMACY MANAGEMENT SERVICES, INC.
4224 Henderson Boulevard ☐ P.O. Box 320178
Tampa, Florida 33679 ☐ (813) 254-7676
1-800-237-7676 (Continental U.S.A.)
1-800-282-7676 (Florida only)

DRUG INTERACTION ALERT

Attached is an example of a potentially adverse drug-drug interaction whose severity level is graded as "moderate."

Our computer produces an ALERT whenever the combinations of drugs that our pharmacists enter show potential contraindications. These will be classified as "mild," "moderate" or "severe."

```
DIL120 15:25:25 10/02/84 DRUG INTERACTION ALERT                     PAGE  1

THIS REPORT PREPARED BY PHARMACY MANAGEMENT SERVICES, INC.

P H A R M A C I S T   D A T A

PATIENT NAME:            STAN HARRELL
PATIENT I.D.:
CLAIM NUMBER:            TEST CASE

CARRIER NAME:
CARRIER CITY STATE ZIP:
---------------------------------------------------------------------
P R E A M B L E   O F   D R U G S   C O N S I D E R E D
---------------------------------------------------------------------

 1ST DRUG: 0369080301   THEO-DUR 300MG SA

 2ND DRUG: 0108501320   TAGAMET 300MG

 3RD DRUG: 0140000501   VALIUM 5MG
```

```
DIL120 15:25:25 10/02/84 FOR YOUR INFORMATION....  PAGE  1

THIS REPORT PREPARED BY PHARMACY MANAGEMENT SERVICES, INC.

P A T I E N T   I N F O R M A T I O N

PATIENT NAME:            STAN HARRELL
PATIENT I.D.:
CLAIM NUMBER:            TEST CASE

CARRIER NAME:
CARRIER CITY STATE ZIP:
--------------------------------------------------------------
 P R E A M B L E   O F   D R U G S   C O N S I D E R E D
--------------------------------------------------------------

  1ST DRUG: 0369080301   THEO-DUR 300MG SA

  2ND DRUG: 0108501320   TAGAMET 300MG

  3RD DRUG: 0140000501   VALIUM 5MG
```

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DIL120 15:25:25 10/02/84 DRUG INTERACTION ALERT                 PAGE  1

THIS REPORT PREPARED BY PHARMACY MANAGEMENT SERVICES, INC.

P H A R M A C I S T   D A T A

PATIENT NAME:             STAN HARRELL
PATIENT I.D.:
CLAIM NUMBER:             TEST CASE

CARRIER NAME:
CARRIER CITY STATE ZIP:

DATA ON  1ST DRUG:
NDC NUMBER:               0369080301
ITEM DESCRIPTION:         THEO-DUR 300MG SA

DATA ON  2ND DRUG:
NDC NUMBER:               0108501320
ITEM DESCRIPTION:         TAGAMET 300MG
------------------------------------------------------------------------

                  ********INTERACTION*********
                  ****************************
                  *THEOPHYLLINES             *
                  *INCREASED IN EFFECT BY    *
                  *CIMETIDINE                *
                  ****************************

REFERENCES:        SEVERITY LEVEL:
------------------ -----------------------------------------------------

MEDIPHOR:  PAGE 496 2-MODERATE INTERACTION (AVOID IF POSSIBLE)
OTHER: N   PAGE 111 2-MODERATE INTERACTION (AVOID IF POSSIBLE)
------------------------------------------------------------------------
ALERT: THEO-DUR 300MG SA           . ALERT: TAGAMET 300MG
---------------------------------- . -----------------------------------
INCREASED FLUID-INTAKE AIDS        . FOOD/MILK AIDS DRUG ABSORPTION OR
MEDICINAL ACTION (FORCE FLUIDS)    . DECREASES POSSIBLE GI UPSET
                                   .
SOME NON-RX MEDICATIONS MAY BE     . PATIENT COMPLIANCE IMPORTANT FOR
CONTRAINDICATED/USE WITH CAUTION   . EFFICACIOUS THERAPY
                                   .
IF GI DISTRESS OCCURS              . USE CAUTION WHEN DRIVING
MAY BE TAKEN WITH MEALS            . OR OPERATING MACHINERY
                                   .
MAY PRODUCE CNS STIMULATION        . NO ANTACIDS SIMULTANEOUSLY
                                   . (2 HOUR SEPARATION)
                                   .
PROTECTIVE COATING/DELIVERY SYSTEM . CAUTION WITH CONCOMITANT ORAL
MAY BE NEGATED IF CHEWED           . ANTICOAGULANT THERAPY
                                   .
DRUG MAY EXHIBIT ADVERSE SIDE      . MAY CAUSE BLOOD DYSCRASIAS
EFFECTS/ALERT PATIENT ACCORDINGLY  .
                                   .
MAY CAUSE DIZZINESS IN ELDERLY AT  .
START OF THERAPY                   .
                                   .
TAKE ON EMPTY STOMACH              .
FOR TEST RESULTS                   .
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DIL120 15:25:25 10/02/84 FOR YOUR INFORMATION....  PAGE  1

THIS REPORT PREPARED BY PHARMACY MANAGEMENT SERVICES, INC.

P A T I E N T   I N F O R M A T I O N

PATIENT NAME:             STAN HARRELL
PATIENT I.D.:
CLAIM NUMBER:             TEST CASE

CARRIER NAME:
CARRIER CITY STATE ZIP:

DATA ON  1ST DRUG:
NDC NUMBER:               0369080301
DRUG NAME:                THEO-DUR 300MG SA

DATA ON  2ND DRUG:
NDC NUMBER:               0108501320
DRUG NAME:                TAGAMET 300MG
------------------------------------------------------------
PLEASE NOTE THE FOLLOWING MESSAGES UNDER THE DRUG NAMES.
------------------------------------------------------------
 THEO-DUR 300MG SA          .   TAGAMET 300MG
------------------------------------------------------------
 TAKE MEDICATION WITH A     .   TAKE WITH FOOD OR MILK
 FULL GLASS OF WATER        .   (OR IMMEDIATELY AFTER)
                            .
 CONSULT MD/PHARMACIST      .   FOLLOW DIRECTIONS CARE-
 BEFORE TAKING NON-RX MEDS  .   FULLY DO NOT VARY DOSAGE
                            .
 MAY CAUSE INSOMNIA / TAKE  .   USE CAUTION WHEN DRIVING
 4 TO 6 HRS BEFORE BED      .   OR OPERATING MACHINERY
                            .
 DO NOT CHEW                .   NO ANTACIDS SIMULTANEOUS-
 (SWALLOW WHOLE)            .   LY (2 HOUR SEPARATION)
                            .
 PROMPTLY REPORT UNUSUAL    .   REPORT PERSISTANT COLD OR
 SYMPTOMS/EFFECTS TO MD     .   FLU SYMPTOMS TO M.D.
                            .
 TAKE MEDICATION ON         .
 AN EMPTY STOMACH           .
                            .
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564

Theophyllines — *Cimetidine*

Interacting			
Aminophylline* Oxtriphylline*	Theophylline*		
Significance	**Onset**	**Severity**	**Documentation**
	☐ Rapid ■ Delayed	☐ Major ■ Moderate ☐ Minor ☐ None	■ Established ☐ Probable ☐ Suspected ☐ Possible ☐ Doubtful

Effects	Pharmacologic effects of THEOPHYLLINES may be increased. Elevated theophylline plasma levels with toxicity characterized by nausea, vomiting, cardiovascular instability, and seizures may occur.
Mechanism	Impaired metabolism of THEOPHYLLINES due to inhibition of hepatic microsomal enzymes by CIMETIDINE.
Management	May need a lower dose of THEOPHYLLINES during concurrent administration of CIMETIDINE. Monitor theophylline plasma levels and the patient for symptoms of theophylline toxicity; adjust the dose accordingly.

Discussion

Seven controlled studies demonstrate a significant pharmacokinetic interaction between cimetidine and theophylline[1,2,5,7,10-12]. Although considerable interpatient variability exists, cimetidine causes a 20% to 40% reduction in theophylline plasma clearance and prolongs the elimination half-life by as much as 70%. Doses as low as 300 mg/day of cimetidine cause some inhibition of theophylline metabolism[12]. Excessive theophylline levels, associated with toxic symptoms in some patients, have been reported[3,4,6,8,9].

Dyphylline, a less potent theophylline derivative which is renally excreted, probably does not interact with cimetidine. Ranitidine does not significantly alter the clearance of theophylline in most patients[7].

[1] Roberts RK *et al:* Gastroenterology 81:19 (1981).
[2] Jackson JE *et al:* Am Rev Respir Dis 123:615 (1981).
[3] Weinberger MM *et al:* N Engl J Med 304:672 (1981).
[4] Campbell MA *et al:* Ann Intern Med 95:68 (1981).
[5] Reitberg DP *et al:* Ann Intern Med 95:582 (1981).
[6] Lofgren RP *et al:* Ann Intern Med 96:378 (1982).
[7] Breen KJ *et al:* Clin Pharmacol Ther 31:297 (1982).
[8] Bauman JH *et al:* Ann Allergy 48:100 (1982).
[9] Cluxton RJ *et al:* Ann Intern Med 96:684 (1982).
[10] Schwartz JI *et al:* Clin Pharm 1:534 (1982).
[11] Vestal RE *et al:* Br J Clin Pharmacol 15:411 (1983).
[12] DeAngelis C *et al:* Clin Pharm 2:563 (1983).

*Asterisk identifies drugs reported in interaction studies.

Drug Interaction Facts • Copyright© July, 1984 by Facts and Comparisons

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DIL120 15:25:25 10/02/84 DRUG INTERACTION ALERT              PAGE  1

THIS REPORT PREPARED BY PHARMACY MANAGEMENT SERVICES, INC.

P H A R M A C I S T   D A T A

PATIENT NAME:           STAN HARRELL
PATIENT I.D.:
CLAIM NUMBER:           TEST CASE

CARRIER NAME:
CARRIER CITY STATE ZIP:

DATA ON  1ST DRUG:
NDC NUMBER:             0369080301
ITEM DESCRIPTION:       THEO-DUR 300MG SA

DATA ON  2ND DRUG:
NDC NUMBER:             0108501320
ITEM DESCRIPTION:       TAGAMET 300MG
--------------------------------------------------------------------

                  ********INTERACTION********
                  ***************************
                  *THEOPHYLLINES            *
                  *INCREASED IN EFFECT BY   *
                  *CIMETIDINE               *
                  ***************************

REFERENCES:         SEVERITY LEVEL:
------------------ -------------------------------------------------

MEDIPHOR:  PAGE 496 2-MODERATE INTERACTION (AVOID IF POSSIBLE)
OTHER: N.  PAGE 111 2-MODERATE INTERACTION (AVOID IF POSSIBLE)
--------------------------------------------------------------------
ALERT: THEO-DUR 300MG SA            . ALERT: TAGAMET 300MG
----------------------------------- . -------------------------------
INCREASED FLUID-INTAKE AIDS         . FOOD/MILK AIDS DRUG ABSORPTION OR
MEDICINAL ACTION (FORCE FLUIDS)     . DECREASES POSSIBLE GI UPSET
                                    .
SOME NON-RX MEDICATIONS MAY BE      . PATIENT COMPLIANCE IMPORTANT FOR
CONTRAINDICATED/USE WITH CAUTION    . EFFICACIOUS THERAPY
                                    .
IF GI DISTRESS OCCURS               . USE CAUTION WHEN DRIVING
MAY BE TAKEN WITH MEALS             . OR OPERATING MACHINERY
                                    .
MAY PRODUCE CNS STIMULATION         . NO ANTACIDS SIMULTANEOUSLY
                                    . (2 HOUR SEPARATION)
                                    .
PROTECTIVE COATING/DELIVERY SYSTEM  . CAUTION WITH CONCOMITANT ORAL
MAY BE NEGATED IF CHEWED            . ANTICOAGULANT THERAPY
                                    .
DRUG MAY EXHIBIT ADVERSE SIDE       . MAY CAUSE BLOOD DYSCRASIAS
EFFECTS/ALERT PATIENT ACCORDINGLY   .
                                    .
MAY CAUSE DIZZINESS IN ELDERLY AT   .
START OF THERAPY                    .
                                    .
TAKE ON EMPTY STOMACH               .
FOR TEST RESULTS                    .
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. DIL120 15:25:25 10/02/84 FOR YOUR INFORMATION....  PAGE  1
.
. THIS REPORT PREPARED BY PHARMACY MANAGEMENT SERVICES, INC.
.
. P A T I E N T   I N F O R M A T I O N
.
. PATIENT NAME:           STAN HARRELL
. PATIENT I.D.:
. CLAIM NUMBER:           TEST CASE
.
. CARRIER NAME:
. CARRIER CITY STATE ZIP:
.
. DATA ON  1ST DRUG:
. NDC NUMBER:             0369080301
. DRUG NAME:              THEO-DUR 300MG SA
.
. DATA ON  2ND DRUG:
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. PLEASE NOTE THE FOLLOWING MESSAGES UNDER THE DRUG NAMES.
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. --------------------------  ---------------------------
.  TAKE MEDICATION WITH A     .  TAKE WITH FOOD OR MILK
.  FULL GLASS OF WATER        .  (OR IMMEDIATELY AFTER)
.                             .
.  CONSULT MD/PHARMACIST      .  FOLLOW DIRECTIONS CARE-
.  BEFORE TAKING NON-RX MEDS  .  FULLY DO NOT VARY DOSAGE
.                             .
.  MAY CAUSE INSOMNIA / TAKE  .  USE CAUTION WHEN DRIVING
.  4 TO 6 HRS BEFORE BED      .  OR OPERATING MACHINERY
.                             .
.  DO NOT CHEW                .  NO ANTACIDS SIMULTANEOUS-
.  (SWALLOW WHOLE)            .  LY (2 HOUR SEPARATION)
.                             .
.  PROMPTLY REPORT UNUSUAL    .  REPORT PERSISTANT COLD OR
.  SYMPTOMS/EFFECTS TO MD     .  FLU SYMPTOMS TO M.D.
.                             .
.  TAKE MEDICATION ON         .
.  AN EMPTY STOMACH           .
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564

Theophyllines — *Cimetidine*

Interacting	
Aminophylline* **Oxtriphylline***	**Theophylline***

Significance	**Onset**	**Severity**	**Documentation**
	☐ Rapid	☐ Major	■ **Established**
	■ Delayed	■ Moderate	☐ Probable
		☐ Minor	☐ Suspected
		☐ None	☐ Possible
			☐ Doubtful

Effects	Pharmacologic effects of THEOPHYLLINES may be increased. Elevated theophylline plasma levels with toxicity characterized by nausea, vomiting, cardiovascular instability, and seizures may occur.
Mechanism	Impaired metabolism of THEOPHYLLINES due to inhibition of hepatic microsomal enzymes by CIMETIDINE.
Management	May need a lower dose of THEOPHYLLINES during concurrent administration of CIMETIDINE. Monitor theophylline plasma levels and the patient for symptoms of theophylline toxicity; adjust the dose accordingly.

Discussion

Seven controlled studies demonstrate a significant pharmacokinetic interaction between cimetidine and theophylline[1,2,5,7,10-12]. Although considerable interpatient variability exists, cimetidine causes a 20% to 40% reduction in theophylline plasma clearance and prolongs the elimination half-life by as much as 70%. Doses as low as 300 mg/day of cimetidine cause some inhibition of theophylline metabolism[12]. Excessive theophylline levels, associated with toxic symptoms in some patients, have been reported[3,4,6,8,9].

Dyphylline, a less potent theophylline derivative which is renally excreted, probably does not interact with cimetidine. Ranitidine does not significantly alter the clearance of theophylline in most patients[7].

[1] Roberts RK *et al*: Gastroenterology 81:19 (1981).
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[10] Schwartz JI *et al*: Clin Pharm 1:534 (1982).
[11] Vestal RE *et al*: Br J Clin Pharmacol 15:411 (1983).
[12] DeAngelis C *et al*: Clin Pharm 2:563 (1983).

*Asterisk identifies drugs reported in interaction studies.

To Help You Benefit From Your

MAIL ORDER PRESCRIPTION DRUG PROGRAM...

Here are answers to the most frequently asked questions.

Prepared by
NATIONAL Rx SERVICES, INC.
for Subscribers of
The Blue Cross and Blue Shield
Service Benefit Plan

ANSWERS To Your QUESTIONS

Hundreds of thousands of Blue Cross and Blue Shield Service Benefit Plan subscribers have taken advantage of the new mail order prescription drug program since it was introduced in January. Over the past several months, many subscribers have called National Rx Services in Tampa with questions. This brochure presents answers to some of the more frequently asked questions so that all subscribers will have a better understanding of the Mail Order Prescription Drug Program.

Q. WHAT IF I HAVE QUESTIONS CONCERNING MY ORDER OR THE PROGRAM?

A. National Rx Services encourages you to call or write if you have further questions concerning the Mail Order Prescription Drug Program. We would like to have your suggestions on how we can improve our service to you. A customer service representative or registered pharmacist is available from 8:00 A.M. to 8:00 P.M. Eastern Standard Time. Toll-Free Number: 1-800-262-7890.

Q. I RECEIVED LESS THAN A 90-DAY SUPPLY, WHY?

There are three reasons why you may not have received the maximum, 90 day supply.

A. 1 — Your physician may have prescribed less than a 90 day supply. Although the Service Benefit Plan allows for the dispensing of up to a 90 day supply, the pharmacy can only dispense the quantity prescribed by your doctor. Your physician may not always want you to have a 90 day supply, especially if there is the possibility that your medication or dosage may be changed.

2 — Controlled Substances:
Certain controlled substances are restricted by Federal Law to only 30, 60 or 90 day supplies.

3 — Other Restrictions:
A small number of drugs have dispensing limitations recommended by the drug manufacturer. Examples are Methaltrexate, Halcion, and Placidyl.

Q. WHAT DRUGS ARE NOT COVERED UNDER THE MAIL ORDER DRUG PROGRAM?

A. There are basically six types of drugs that may be excluded from this program:

1. over-the-counter drugs.
2. drugs requiring constant refrigeration.
3. drugs that must be administered by physicians in a clinical setting.
4. drugs whose bulk weight is so great as to be impractical for mailing.
5. experimental drugs.
6. drugs which require medical review by the local Blue Cross and Blue Shield Plan to determine if they are required for the treatment of a condition. (Examples are birth control pills and weight control drugs, such as amphetamines.)

Q. CAN MY MEDICATION BE SENT DIRECTLY TO MY NURSING HOME?

A. Yes. If you or an eligible dependent is in a nursing home, please indicate the name and address of the nursing home on your order envelope.

Q ARE GENERIC DRUGS AS GOOD AS BRAND NAME DRUGS?

A. ABSOLUTELY. By law, generic and brand name drugs must meet the same standards for safety, purity and effectiveness. When you and your doctor authorize generic substitution, it permits the pharmacy to dispense a generic drug when available.

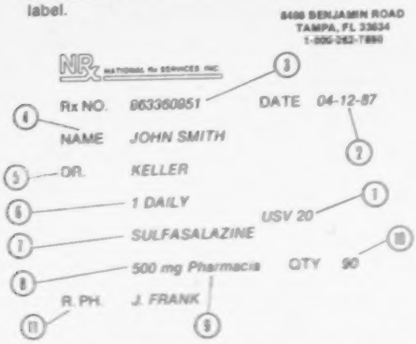
Q. IF I CHANGE OPTIONS WITHIN THE SERVICE BENEFIT PLAN, WHAT WILL MY CO-PAYMENT BE?

A. The co-payment for the Standard Option is $5.00 per prescription and $3.00 per prescription for the High Option. There is no co-payment if you are enrolled in Medicare B. If you change options, please send the appropriate co-payment with your order.

© National Rx Services, Inc

Q. WHAT INFORMATION IS ON THE PRESCRIPTION'S LABEL?

A. The diagram below is designed to help you understand all the information printed on your label.



1. The manufacturer's identification number that appears on the tablet or capsule when applicable.
2. The date that National Rx Services, Inc. filled the prescription.
3. Each prescription filled by National Rx Services, Inc. is assigned a unique number.
4. The patient's name.
5. The doctor's name.
6. The directions.
7. The name of the drug dispensed.
8. The potency of the drug.
9. The manufacturer of the product.
10. The quantity dispensed.
11. Registered Pharmacist who dispensed the prescription.

Q. CAN NATIONAL Rx SERVICES ADD EXPIRATION DATES TO THE PRESCRIPTION LABEL?

A. National Rx Services will be adding expiration dates to the prescription label in the Fall of 1987.

TOLL FREE NUMBER: 1-800-262-7890

The submission of your prescription (or those of family members covered by the Service Benefit Plan) constitutes full consent and express authorization to National Rx Services, Inc. to release all information pertaining to the enclosed prescription(s) to the plan administrator, underwriter, sponsor, policyholders, and the employer.

Q. WHAT IS THE DEA NUMBER?

A. The DEA number is an identification number assigned by the Drug Enforcement Agency (DEA) to your doctor. All prescriptions for controlled substances require that the DEA number appear on the prescription.

Q. HOW DO I GET STARTED USING THE PROGRAM?

A. Enclosed is a pre-addressed, postage-paid order envelope. Simply fill out all the requested information, enclose your prescriptions and the appropriate co-payment (Standard Option: $5.00 per prescription; High Option: $3.00 per prescription. There is no co-payment if you are covered under Medicare B.) **Please make your checks payable to National Rx Services, Inc.**

Q. HOW LONG WILL IT TAKE TO RECEIVE MY PRESCRIPTION ONCE I HAVE MAILED IN THE PRE-ADDRESSED, POSTAGE-PAID ENVELOPE?

A. Normally you will receive your prescription in about 10 days. If your prescription has to be researched (e.g., a call to your doctor is required) it could take as long as 14 days. Under most circumstances we will fill and mail your prescription within 48 hours of receipt.

Q. HOW CAN I UPDATE MY MEDICAL PATIENT PROFILE WITH NATIONAL Rx SERVICES IN TAMPA?

A. If you are a new program user or if you wish to update your profile, complete the attached patient profile questionnaire and submit it separately or with your next prescription order in the enclosed pre-addressed reply envelope.

National Rx Services, Inc.
8408 Benjamin Road
Tampa, FL 33634

A Subsidiary of MEDCO Containment Services, Inc.

DETACH ALONG DOTTED LINE

Please show this portion TO YOUR PHYSICIAN so he/she can learn more about the program

Dear Physician:

Your patient is enrolled in a **maintenance prescription drug program** which permits up to a **90 day supply** of medication when so prescribed by you. Refills, when authorized by you, are permitted to a maximum of one year except where prohibited by law.

We request your cooperation in prescribing **generic drugs** whenever possible, and medication quantities to the plan's 90 day maximum when appropriate. **This request is not intended to compromise your judgment, nor is it a request to order medication that will not be used.**

> **Example:** If a patient takes one tablet a day, please write for the exact quantity of 90 tablets with three refills . . . two daily, prescribe 180, etc. Please specify the exact quantity you wish. When applicable, please include your DEA number and either use a form showing your name clearly or print your name. Please include daily directions, proper strengths, the exact number of refills, and **generic names of the medication.**

If you have any questions concerning this program, please contact National Rx Services' Customer Service Department, Monday through Friday, from 8:00 A.M. to 8:00 P.M. Eastern Standard Time. Toll Free Number: 1-800-262-7890.

THANK YOU FOR YOUR COOPERATION
National Rx Services, Inc.

DETACH ALONG DOTTED LINE

Complete and Mail With Your Prescription Order

CONFIDENTIAL SUBSCRIBER/PATIENT PROFILE(S) QUESTIONNAIRE

NRx **NATIONAL Rx SERVICES, INC.**

Please complete the Patient Profile for you and each of your dependents indicating any drug allergies, health conditions, chronic diseases or sensitivity to any drug(s). This information will be used to check any potential drug interactions when you have prescriptions filled through National Rx Services, Inc. If there are no allergies, chronic diseases or drug sensitivities, please check "None". All forms must be signed. **PLEASE PRINT OR TYPE.**

BLUE CROSS AND BLUE SHIELD SERVICE BENEFIT PLAN

Please note: It is the patient's responsibility to report to National Rx Services, Inc. changes in drug allergies, health conditions, chronic diseases or drug sensitivities.

Subscriber ID # as it appears on your Service Benefit Plan ID Card. R ☐☐☐☐☐☐☐☐ F E P 1 0 ☐

Subscriber Name ____________________ First MI Last

Address ____________________ Street City State Zip

COMPLETE and MAIL

COMPLETE ON REVERSE SIDE

DETACH ALONG DOTTED LINE

COMPLETE and MAIL

PRINT OR TYPE

			ALLERGIES					HEALTH CONDITIONS							
INCLUDE LAST NAMES IF NOT THE SAME AS CONTRACT HOLDER	Date of Birth	Sex	None	Penicillin	Chocolate	Sulfur	Aspirin	Thyroid	Diabetes	Glaucoma	Heart Condition	High Blood Press.	Lung Condition	Intestinal Disorders	Other Allergies or Health Conditions
Contract Holder's Name															
Spouse's First Name															
Child's First Name															
Child's First Name															
Child's First Name															

Subscriber's Signature ______________________ Date ____________

Daytime Telephone Number ______________________

COMPLETE ON REVERSE SIDE

(Your Company Name/Logo)

MAIL ORDER PRESCRIPTION DRUG BENEFIT

A new convenient method for obtaining your prescription needs...

EXPRESS
PHARMACY SERVICES
Rx
ision of JCPenney Co., Inc.

WHAT ABOUT GENERIC DRUGS?

Generic drugs have become very popular in the last few years. The generic name of a drug is simply its chemical name. By law, brand name drugs and generic drugs must be the same chemically and also have the same therapeutic effect. Generic drugs meet strict requirements under the FDA and are as safe, efficient and effective as brand name drugs, but considerably less expensive. Please discuss with your doctor the possibility of writing your prescriptions generically. Unless otherwise specified by your doctor, your prescription will be filled generically if legally available in that form.

BEFORE LEAVING THE DOCTOR'S OFFICE:

- Discuss the possibility of prescribing your medication generically.
- Examine the prescription to make sure the dosage has been included, the doctor's signature, and your name and address are shown.
- Have your doctor write your prescription for a 90-day supply with three (3) refills.
- If you need medication immediately, ask your doctor to issue two prescriptions — one for a 14-day supply to be taken to your local pharmacy and a second for an extended days' supply to be mailed to Express Pharmacy Services.

WHAT ARE THE QUALITY STANDARDS?

Express Pharmacy Services, a division of JCPenney Co. Inc., guarantees that all prescriptions will meet the highest pharmaceutical standards of quality, safety, and effectiveness. Each and every prescription is filled and checked by highly qualified registered pharmacists to assure that the quantity, quality and potency are accurate. A patient profile is maintained to insure that there are no adverse reactions with other prescriptions you are receiving from Express Pharmacy Services. If any questions arise regarding potential drug interactions or other adverse reactions, the pharmacist will contact your doctor or you before dispensing the medication.

CONFIDENTIAL PATIENT PROFILE

List each covered family member who has a drug allergy or health condition. This information will be used to check potent drug interactions when you have prescriptions filled through Express Pharmacy Services.

INCLUDE LAST NAMES IF NOT THE SAME AS EMPLOYEE/RETIREE	ALLERGIES					HEALTH CONDITIONS							
	None	Penicillin	Chocolate	Sulfa	Aspirin	Thyroid	Diabetes	Glaucoma	Heart Conditions	High Blood Pressure	Lung Conditions	Intestinal Disorders	Other
Employee/Retiree Name													
Eligible Dependent(s)													

If additional space is needed, please list other allergies or health conditions.

____

____

____

PLEASE NOTE AND SIGN:

I certify that the information provided on this form is correct and that any of my dependents for whom prescriptions a enclosed do not have prescription drug coverage under any other group medical or drug plan that is "primary" under the nc duplication or Coordination of Benefits provision of the company sponsored health program. I further authorize release of information to the program sponsor, plan administrator or underwriter. I also authorize Express Pharmacy Services substitute generic drugs in all cases where legally permissable.

______________________ (Date Signed)

______________________ (Employee's/Retiree's Signature)

WHEN SHOULD I USE THE MAIL ORDER PROGRAM?

The [illegible] has been designed mainly for individuals using [illegible] type medication for the treatment of chronic or long term conditions such as diabetes, arthritis, heart conditions and high blood pressure.

If you are using one or more medications for periods of 30 days or longer, the program provides cost savings to you, the convenience of home delivery and toll free customer service numbers.

WHAT IS COVERED?

The mail order drug program covers any drugs which by law of the United States, requires a doctor's prescription and are covered by your company's medical plan.

WHAT IS NOT COVERED?

This program does not cover any medicine that can be purchased over-the-counter, oral contraceptives, fertility drugs, vitamins or any drug the requires refrigeration. Also, certain "controlled" substances (called schedule II drugs) are limited to a 30-day supply with no refills permitted.

WHO IS ELIGIBLE FOR BENEFITS?

There is no change in eligibility. If you and your family are presently covered for outpatient prescription drugs under your Group/Company medical plan, you are eligible to enroll in the mail service program.

HOW DO I SAVE MONEY AND TIME?

You can save out-of-pocket prescription drug expenses and time by ordering medication through the mail.

If you or an eligible family member is taking medication on a regular basis, you presently pay the full cost of each prescription, accumulate your bills, and then file your claim. After your deductible level is met, you are reimbursed a portion of the actual amount of the cost.

Using mail order, the cost is not subject to the annual deductible. You can get up to a 90-day supply at one time, paying $______ per prescription. The balance will be billed to your company. You will save time by no longer accumulating bills and filing claims.

NOTE: If you are using a credit card for your payment the following credit cards are honored:

- JCPenney
- MasterCard
- VISA
- American Express

If you don't have a credit card, call one of the following numbers for a JCPenney credit card application:

HOW DO I USE THE MAIL ORDER DRUG PROGRAM?

1. When your doctor prescribes a maint[illegible] drug have it written for up to a 90-day sup[illegible]y law, Express Pharmacy Services can only fill your prescriptions with the quantity indicated by your doctor.
   - Example:

   1 a day   90 pills
   2 a day   180 pills
   liquid, vials or creams – exact quantity
2. Complete both sides of the attached Enrollment/Order Form and Patient Profile questionnaire. This form will only need to be completed with your first order. List any allergies, drug sensitivities and health conditions. Please answer all the questions.
3. Mail this completed form with the original prescription (not a photocopy) and the $______ copayment in the pre-addressed postage paid envelope provided. The copayment can be in the form of a check, money order or credit card charge JCPenney, MasterCard, Visa or American Express.
4. Be sure the Employee/Retiree Social Security number is on the back of each prescription.
5. Drugs will be delivered postage paid by First Class Mail or United Parcel Service directly to your home. Please allow 14 days for delivery from the day you place your order. Allow a few extra days for first submissions.
6. To reorder or refill:
   - When you need a refill, place your order three weeks prior to the time your current supply of medication runs out to allow for mail delivery.
   - Follow the instructions on the postage-paid reorder envelope, included with each order.
   - You may call Express Pharmacy Services toll-free at the listed numbers; give your prescription number(s) and credit card information.
   - You will be allowed only the number of refills noted on the original prescription.
7. If you have any questions or problems concerning your prescription order, please contact Express Pharmacy Services toll-free. If you do not receive your medication in 14 days please call. If a replacement is necessary it will be filled promptly and sent to you at no additional charge.

FOR MORE INFORMATION CONTACT:

- General program information:

Hours: 8:00 AM to 9:00 PM Eastern Time

- Questions concerning prescriptions and deliveries

Hours: 8:00 AM to 9:00 PM Eastern Time, Mon.-Fri.
8:00 AM to 3:00 PM Eastern Time, Sat.

DETACH HERE

ENROLLMENT/ORDER FORM

DETACH HERE

Express Pharmacy Services.

Please complete this form and return it to Express Pharmacy Services in the enclosed pre-addressed envelope. Be sure to sign the form, enclose your initial **original prescription(s)** and **payment or charge information.**

MAIL ORDER DRUG PROGRAM

EMPLOYEE/RETIREE SOCIAL SECURITY NUMBER ☐☐☐-☐☐-☐☐☐☐

Please fill in Group/Company Name ______________________________

Employee/Retiree Name ______________________________ SEX M F
First MI Last

Address ______________________________
Street City State Zip

Daytime Phone Number (______) ________________ Date of Birth ________

Dependent ________________ Relationship __________ Date of Birth ________ Sex ____

Dependent ________________ Relationship __________ Date of Birth ________ Sex ____

Dependent ________________ Relationship __________ Date of Birth ________ Sex ____

Dependent ________________ Relationship __________ Date of Birth ________ Sex ____

Number of prescriptions enclosed ______ x $____ copayment per prescription = $ ______ total copayment

Prescriptions are for: ☐ Employee/Retiree ☐ Spouse ☐ Son ☐ Daughter ☐ Other ________________ (name)

☐ Check here if child proof caps are not required.

Payment is being made by: Check ☐ Money Order ☐ Credit Card ☐

Please make check or money order payable to Express Pharmacy Services.

If you use a credit card, please identify the card, VISA, MasterCard, American Express, or JCPenney, give account number and expiration da

JCPenney ☐ MasterCard ☐ VISA ☐ American Express ☐

Account Number ______________________________ Expiration Date ____

Please Present This Portion TO YOUR PHYSICIAN

Dear Doctor:

Your patient is enrolled in a mail order maintenance prescription drug program.

The plan requests your cooperation in prescribing generic drugs whenever possible. It is not the intention of Express Pharmacy Services to demand generic substitution but the economic viability of the insurance program requires that we make reasonable efforts to minimize the cost to the employee and their company.

We appreciate your cooperation in:

- Writing specific quantities of drugs; for up to 90 days when appropriate.
- Including your DEA number, where applicable.
- Specifying generic names where possible.

If you have any questions concerning this program, please contact Express Pharmacy Services toll-free at 1-800-445-8252 8:00 a.m. - 9:00 p.m. Eastern Time.

Thank you for your cooperation
Express Pharmacy Services

WHAT ABOUT GENERIC DRUGS?

Generic drugs have become very popular in the last few years. The generic name of a drug is simply its chemical name. By law, brand name drugs and generic drugs must be the same chemically and also have the same therapeutic effect. Generic drugs meet strict requirements under the FDA and are as safe, efficient and effective as brand name drugs, but considerably less expensive.

COMMON BRAND NAME DRUGS AND THEIR MONEY SAVING GENERIC EQUIVALENTS

Brand Name	Generic Equivalent
Aldactazide	Spironolactone
Aldomet	Methyldopa
Apresoline	Hydralazine
Ativan	Lorazepam
Catapres	Clonidine
Dalmane	Flurazepam
Darvocet-N	Propoxyphene Napsylate
Diabinese	Chlorpropamide
Enduron	Methyclothiazide
Hydrodiuril	Hydrochlorothiazide
Hygroton	Chlorthalidone
Inderal	Propranolol
Indocin	Indomethacin
Isordil	Isosorbide Dinitrate
Lasix	Furosemide
Motrin	Ibuprofen
Persantine	Dipyridamole
Premarin	Conjugated Estrogens
Synthroid	L-Thyroxine Sodium
Valium	Diazepam
Zyloprim	Allopurinol

STATE ATTORNEY GENERAL OPINIONS ON OUT-OF-STATE PHARMACY OPERATIONS

State of Tennessee

OFFICE OF THE ATTORNEY GENERAL
450 JAMES ROBERTSON PARKWAY
NASHVILLE, TENNESSEE 37219-5025

W. J. MICHAEL CODY
ATTORNEY GENERAL & REPORTER

JOHN KNOX WALKUP
CHIEF DEPUTY ATTORNEY GENERAL

WILLIAM H. FARMER
ADVOCATE GENERAL

JIMMY G. CREECY
ASSOCIATE CHIEF DEPUTY

ROBERT A. GRUNOW
ASSOCIATE CHIEF DEPUTY

DEPUTY ATTORNEYS GENERAL
DOUGLAS BERRY
DONALD L. CORLEW
PATRICIA J. COTTRELL
R. STEPHEN DOUGHTY
KATE EYLER
ROBERT E. KENDRICK
CHARLES L. LEWIS
FRANK J. SCANLON
JENNIFER H. SMALL
JERRY L. SMITH
JOHN F. SOUTHWORTH, JR.

July 29, 1986
86.132

The Honorable Floyd Crain
State Representative
22 Legislative Plaza
Nashville, Tennessee 37219

Dear Representative Crain:

You have requested the opinion of this office with respect to the following matters:

QUESTIONS

1) Whether Tennessee law authorizes the Tennessee Board of Pharmacy to extend its licensing and registration requirements to out-of-state pharmacies making mail-order sales of prescription medicines to Tennessee residents.

2) Whether pharmacists employed in such pharmacies should be licensed by Tennessee.

3) Whether such regulation of out-of-state pharmacies and pharmacists by the Tennessee Board of Pharmacy imposes an unconstitutional burden on interstate commerce.

4) Whether an out-of-state pharmacy making mail-order sales of prescription medicines to Tennessee residents must comply with T.C.A. § 53-10-104, which limits such sales to no more than 15% of the pharmacy's total volume of business.

5) Whether such out-of-state pharmacies must comply with all Tennessee laws and rules regarding the dispensing of prescription medicines.

OPINIONS

1) Yes. The provisions of T.C.A. §§ 63-10-201, *et seq.* require that all pharmacies, in-state or out-of-state, selling or distributing prescription drugs to persons in Tennessee must be registered and licensed by the Tennessee Board of Pharmacy.

2) Yes. The provisions of T.C.A. §§ 63-10-201, *et seq.* require that all persons compounding, preparing, selling, or dispensing prescription drugs to persons in Tennessee must be licensed and registered by the Tennessee Board of Pharmacy.

3) No. The regulation of sales of prescription drugs to persons in Tennessee is a valid exercise of the state's police power to protect the health and welfare of the public. Tennessee's laws on that subject neither discriminate against nor impose an undue burden upon interstate commerce. Further, such regulation of out-of-state pharmacies and pharmacists by Tennessee does not violate due process.

4) Under T.C.A. § 53-10-104(b), it is unlawful for any person to obtain a legend drug by mail, unless the drug is obtained from a person or firm whose mail-order business is not more than 15% of its total volume of business. The primary incidence of T.C.A. § 53-10-104(b) is upon the customer, or person receiving the drugs.

5) Out-of-state pharmacies dispensing prescription medicines by mail to persons in Tennessee should comply with all Tennessee laws and rules pertaining to dispensing prescription medicines.

ANALYSIS

I.

The powers and duties of the Tennessee Board of Pharmacy are set forth in T.C.A. §§ 63-10-101 through 63-10-217. Those statutes contemplate and provide for thorough regulation, registration, and licensing of pharmacists, pharmacies, and manufacturers, wholesalers, and distributors of prescription drugs, to the full extent that sales and distribution of prescription drugs may affect the public health, safety and welfare of the State of Tennessee.

The system of pharmacy regulation created and authorized by statute recognizes that persons and entitites located outside the State of Tennessee may be involved in the prescription drug business on an interstate scale, but with consequences no less serious for the public health of Tennessee than those caused by pharmacies and pharmacists physically located in this state. Therefore, the Tennessee Board of Pharmacy is empowered by statute to regulate out-of-state entities which introduce prescription drugs into Tennessee.

The extent of the Board's regulatory power is expressed in the language of, for example, T.C.A. § 63-10-210(f):

> No out-of-state manufacturer, wholesaler or pharmacy doing business in this state who has not obtained a license from the board, and who sells or distributes legend drugs in this state, through any person or media other than a wholesaler, who has obtained a license pursuant to the provisions of this chapter or through a selling or distribution outlet, which is licensed as a wholesaler pursuant to the provisions of this chapter, shall conduct the business of selling or distributing legend drugs in this state without obtaining a distributor's license from the board.

Although T.C.A. § 63-10-210(f) apparently applies only to entities "doing business in this state," that term is not specifically defined in the pharmacy statutes. Because the term "doing business" takes on different meanings in different contexts, definitions found in other contexts are not controlling. Tidwell v. Gaines Mfg. Co., 526 S.W.2d 460, 463 (Tenn. 1975). For instance, different factors and considerations control the meaning of "doing business" for purposes of taxation, or of domestication of a corporation, or of service of process. Id. In determining what constitutes "doing business" so as to fall within the ambit of state regulatory programs, the focus is upon the consequences created in the regulating state, and the interest of that state in regulating such activity, rather than upon physical presence, place of contract, or activity in the regulating state. *Travelers Health Ass'n. v. Commonwealth of Virginia*, 339 U.S. 643, 70 S.Ct. 927, 929-30, 94 L.Ed. 1154 (1950).

Mail-order sale and delivery of prescription drugs to Tennessee residents certainly causes consequences in the State of Tennessee. The state has a strong interest in regulating sales of prescription drugs in the exercise of its power and duty to protect the public health and welfare. Therefore, out-of-state persons or firms selling prescription drugs by mail to Tennessee residents might well be considered to be "doing business" in Tennessee sufficiently to be subject to regulation by the Board of Pharmacy.

This conclusion is consistent with a reading of T.C.A. § 63-10-210(f) which places the "doing business" wording into context with the other language of that subsection. Thus, "doing business" may be read as meaning "conduct[ing] the business of selling or distributing legend drugs in this state." Certainly an out-of-state entity which places prescription drugs in the mail for direct delivery to a customer in this state is "selling or distributing" such drugs in this state.

Also, T.C.A. § 63-10-210(f) must be read together with the other provisions of the pharmacy statutes, T.C.A. §§ 63-10-201, *et seq*. T.C.A. § 63-10-207(9) provides:

> Prescriptions cannot be accepted, solicited, collected, or advertised at a location other than a pharmacy for which a license has been issued by the board, and such pharmacy shall be actively engaged in compounding, filling, and dispensing prescriptions.

The language of T.C.A. § 63-10-207(9) is broad and unqualified, and expresses a clear legislative intent to regulate all pharmacies accepting, and implicitly, filling prescriptions, whether such pharmacies are located in-state or out-of-state. The provisions of T.C.A. §§ 63-10-201, *et seq*. read together as one statutory plan, evince the legislative intent to authorize regulation by the Board of Pharmacy of all persons selling or distributing prescription drugs to Tennessee consumers.

Therefore, it is the opinion of this office that the licensing and registration requirements of T.C.A. §§ 63-10-201, *et seq*. extend to pharmacies located out-of-state which make mail-order sales of prescription drugs to Tennessee residents.

II.

Just as the regulatory authority of the Tennessee Board of Pharmacy extends to out-of-state pharmacies selling prescription drugs to Tennessee residents, out-of-state pharmacists are also subject to regulation by the Board.

T.C.A. § 63-10-206 provides:

> The compounding or manufacture and the sale or dispensing of drugs and medicines shall be limited *exclusively* to persons who are registered for that purpose under the provisions of this chapter....The board shall provide for the registration of pharmacists having the right as hereinafter provided, and being subject to the limitations and restrictions respectively made.

[Emphasis supplied.]

T.C.A. § 63-10-201(a)(1) defines "compound" as "to mix substances according to a prescription." "Dispense" is defined as "to put up and sell, distribute, leave with, give away, dispose of, deliver or supply legend drugs." T.C.A. § 63-10-201(a)(3).

T.C.A. § 63-10-201(c) declares:

> Further, it shall be unlawful to engage in the practice of compounding, filling, or dispensing prescriptions of physicians, dentists or veterinarians except by a registered pharmacist....

In addition, T.C.A. § 63-10-212(a)(2) proclaims:

> It shall be unlawful for:

. . .

> Any unlicensed person to prepare or dispense a medical preparation or physician's prescription, or to dispense or sell poisonous medicines except an intern under the immediate supervision of a registered pharmacist.

All of the above-quoted statutes, read individually or together, express an unqualified legislative intent that prescription drugs and medicines shall be "dispensed" in Tennessee "exclusively" by pharmacists licensed by Tennessee. The definition of "dispense" carries no territorial limitations, and must be read as any sale, distribution, or delivery of prescription drugs, whether from in-state or out-of-state.

Therefore, it is the opinion of this office that, under the terms of T.C.A. §§ 63-10-201, *et seq.*, only pharmacists licensed by the Tennessee Board of Pharmacy may lawfully compound prescription drugs for delivery or dispensation in Tennessee. It follows that pharmacists who are employed by out-of-state pharmacies and who prepare prescription drugs for delivery by mail to Tennessee residents must be licensed by Tennessee.

III.

To the extent that the regulatory provisions of T.C.A. §§ 63-10-201, *et seq.* reach out-of-state pharmacies and pharmacists making mail-order sales to Tennessee consumers, those provisions may place a burden upon interstate commerce. Inquiry has been made whether those provisions impose a burden upon interstate commerce in violation of the Commerce Clause, Article I, §8, cl. 3 of the United States Constitution.

Although the Constitution granted Congress the power to regulate interstate commerce, the states retained the power to legislate on matters pertaining to the health, safety and welfare of their citizens, even though such legislation might indirectly affect interstate commerce. *Huron Portland Cement Co. v. Detroit*, 362 U.S. 440, 80 S.Ct. 813, 816, 4 L.Ed.2d 852 (1960); *Austin v. State of Tennessee*, 179 U.S. 343, 21 S. Ct. 132, 139, 45 L.Ed. 224 (1900). State laws and regulations based upon the police power may constitutionally stand so long as they do not discriminate against or disrupt the required uniformity of interstate commerce. *Head v. New Mexico Board of Examiners in Optometry*, 374 U.S. 424, 83 S. Ct. 1759, 1762, 10 L.Ed.

2d 983 (1963); *Huron Portland Cement*, 80 S.Ct. at 818.

> A state statute must be upheld if it "regulates evenhandedly to effectuate a legitimate local public interest, and its effects upon interstate commerce are only incidental...unless the burden imposed on such commerce is clearly excessive in relation to the putative local benefits."

Edgar v. MITE Corp., 457 U.S. 624, 102 S.Ct. 2629, 2639, 73 L.Ed. 2d 269 (1982); *Pike v. Bruce Church, Inc.*, 397 U.S. 137, 90 S.Ct. 844, 847, 25 L.Ed.2d 174 (1970).

State laws regulating the sale of drugs, medicines, and poisons are an appropriate exercise of the state's police power to protect the public health, safety, and welfare. *State v. Foutch*, 155 Tenn. 476, 379, 295 S.W. 469 (1927). The State of Tennessee has a strong and legitimate interest in regulating the persons and entities which prepare and dispense prescription drugs for use by Tennessee residents. T.C.A. § 63-10-101(d).

Regulation of the sale of prescription drugs has not been preempted by Congress. *State v. Scott*, 678 S.W.2d 50, 51 (Tenn. 1984); *Pharmaceutical Society of New York v. Lefkowitz*, 454 F. Supp. 1175 (S.D.N.Y. 1978), *aff'd.*, 586 F.2d 953 (2d Cir. 1978). Therefore, the states may regulate sales of prescription drugs without disturbing any federally-imposed conditions of uniformity on that subject.

Tennessee's statutory plan for regulation of sales of prescription drugs does not discriminate against interstate commerce. T.C.A. §§ 63-10-201, *et seq.* impose exactly the same examination, licensing, registration, and record-keeping requirements upon in-state pharmacies and pharmacists as upon those out-of-state. Examination and registration fees are no more expensive for out-of-state applicants than for those located in Tennessee. Manifestly, Tennessee's pharmacy regulation statutes are "evenhanded" and non-discriminatory.

The burdens imposed upon sales of prescription drugs across state lines into Tennessee are by no means excessive when balanced against the local benefits, and Tennessee's strong interest in protecting public health. The state's interest in ensuring that only professionally trained, qualified persons engage in the business of preparing and dispensing prescription drugs is directly addressed by the examination and licensing requirements of T.C.A. §§ 63-10-201, et seq., and by regulation by the Board of Pharmacy.

Therefore, it is the opinion of this office that regulation, pursuant to T.C.A. §§ 63-10-201, et seq., of out-of-state pharmacies and pharmacists making mail-order sales of prescription drugs, neither discriminates against, nor places an undue burden upon interstate commerce. As applied to out-of-state pharmacies and pharmacists, T.C.A. §§ 63-10-201, et seq. do not violate the Commerce Clause.

Extension of Tennessee's regulatory power to out-of-state persons and entities dispensing prescription drugs by mail into Tennessee does not offend due process as guaranteed by the Fourteenth Amendment to the United States Constitution.

The question of the territorial reach of a state's regulatory power is distinct from the question of the reach of a state's judicial jurisdiction, but both are limited by considerations of due process and fundamental fairness. Martin v. Steubner, 485 F. Supp. 88, 98 (S.D. Ohio 1979), aff'd., 652 F. 2d 652 (6th Cir. 1981), cert. denied, 454 U.S. 1148, 102 S.Ct. 1013, 71 L.Ed.2d 302 (1982). Thus, due process may be violated when a state's regulatory or judicial power is exerted unfairly against residents lacking certain "minimum contacts" with that state.

In the context of a state's regulatory jurisdiction and exercise of police powers, analysis of "minimum contacts" is not controlled by technical matters such as physical presence or place of contracting or performance. Instead, "great weight" is accorded to the consequences caused in the regulating state, and the degree of that state's interest in regulating the subject matter. Traveler's Health Ass'n., 70 S.Ct. at 929-30. Particularly "where business activities reach out beyond one state and create continuing relationships and obligations with citizens of another state, courts need not resort to a fictional 'consent'", or other technicalities, "in order to sustain the jurisdiction of regulatory agencies in the latter state." Id., 70 S.Ct. at 929.

Courts have applied the "consequences" and "state interests" analysis to uphold state regulatory provisions against nonresidents with narrow contacts with the regulating state. The registration provisions of Virginia's Securities Act were held enforceable against nonresident securities dealers whose only contacts with Virginia were by mail, telephone, and advertising. Underhill Associates, Inc. v. Bradshaw, 674 F.2d 293 (4th Cir. 1982). In the view of the Underhill court,

> It is not only desirable, but Virginia's interest in protecting its citizens from possibly dishonest or incompetent securities dealers is obvious.

Id., 674 F.2d at 295.

Other courts have upheld the regulatory provisions of state consumer credit laws against mail-order retail firms whose only contacts with the regulating states were by mail and telephone. Aldens, Inc. v. Miller, 610 F.2d 538 (8th Cir. 1979), cert. denied, 446 U.S. 919, 100 S.Ct. 1853, 64 L.Ed.2d 273 (1980) (Iowa Consumer Credit Code); Aldens, Inc. v. Ryan, 571 F.2d 1159 (10th Cir. 1978), cert. denied, 439 U.S. 860, 99 S.Ct. 180, 58 L.Ed.2d 169 (1978) (Oklahoma Consumer Credit Code); Aldens, Inc. v. LaFollette, 552 F.2d 745 (7th Cir. 1977), cert. denied, 434 U.S. 880, 98 S.Ct. 236, 54 L.Ed.2d 161 (1977) (Wisconsin Consumer Act); Aldens, Inc. v. Packel, 524 F.2d 38 (3d Cir. 1975), cert. denied, 425 U.S. 943, 96 S.Ct. 1684, 48 L.Ed.2d 187 (1976) (Pennsylvania Installment Sales Act). In those cases, the courts found that the regulating states had strong interests in protecting their citizens against fraud and overreaching, and usurious credit terms. See LaFollette, 552 F.2d at 751.

In a Sixth Circuit case, the court upheld enforcement of Ohio's Blue Sky Law against a Minnesota securities dealer. Martin, 485 F.Supp. 88. In Martin, the nonresident's only contacts with Ohio were the placement of advertising in the midwestern regional edition of the Wall Street Journal, and the mailing of two letters and a subscription agreement to an Ohio resident. Id., 485 F.Supp. at 100-101. The Martin court carefully weighed the state's interest against the nonresident's minimal contacts.

> As the only nexus of a single, isolated transaction with Ohio, these acts may not be sufficient, by themselves, to justify the extension of Ohio's regulatory legislation to defendants. But viewed together with the state's interest in protecting its citizens from the sale of securities which have not been first subjected to the State's investigative and evaluative processes, such an extension does not appear unfair or to offend due process concepts. The relationship created was isolated, but not short-termed. The State's interest in protecting its citizens with respect to such an investment is strong.

Id.

Applying the "consequences" and "state interests" due process analysis to Tennessee's regulation of out-of-state pharmacies and pharmacists, such regulation should be sustained. Out-of-state pharmacies providing prescription drugs by mail in conjunction with employee benefit plans, insurance coverage, and other long-term contractual relationships are involved in "continuing relationships and obligations with citizens" of the regulating state, as were held subject to regulation in Traveler's Health Ass'n. and Martin. The mailing of prescription drugs into Tennessee causes consequences in this state directly affecting the health and safety of Tennessee consumers.

Further, Tennessee certainly has a very strong interest in regulating such pharmacies and pharmacists so as to protect its citizens against fraud, incompetence, and health and safety hazards. In a field requiring scientific and medical expertise, and in which errors in filling or delivering prescriptions can cause significant injuries or death even to wary consumers, the interest of the state in exercising broad police powers to protect the public finds its most classic expression.

In the opinion of this office, therefore, the provisions of Tennessee's pharmacy statutes, T.C.A. §§ 63-10-201, et seq., as applied to out-of-state pharmacies and pharmacists dispensing prescription drugs by mail to Tennessee consumers, offend neither the Commerce Clause nor due process, and are constitutional.

IV.

Inquiry has also been made regarding the applicability of T.C.A. § 53-10-104(b) to out-of-state pharmacies and pharmacists. That subsection provides:

> It shall be unlawful for any person, firm, or corporation to obtain or to attempt to obtain a legend drug, or to procure or to attempt to procure the administration of a legend drug, by fraud, deceit, misrepresentation, subterfuge, forgery, alteration of a prescription, by the concealment of a material fact, or by the use of a false name or address, provided, however, it shall nevertheless be unlawful for any person to have such prescription filled by mail. The provisions of the proviso to the preceding sentence shall not apply to any firm or person whose mail order business is not more than fifteen percent (15%) of his or its total volume of business.

The plain language of T.C.A. § 53-10-104(b) indicates a legislative intent to criminalize the obtaining of drugs under certain circumstances. The onus of the statute is upon the person obtaining the drugs, i.e., the Tennessee user, rather than upon the out-of-state supplier.

To the extent that the 15% limit on mail-order transactions applies to out-of-state pharmacists and pharmacies, that provision may burden interstate commerce. However, as in the analysis above of T.C.A. §§ 63-10-201, et seq., the burden is nondiscriminatory, and is not excessive in relation to the local benefits. The 15% limitation applies equally to in-state and out-of-state drug suppliers. Further, the limitation is rationally related and directed to limiting the potential for fraud, as well as errors and hazards in the dispensing of prescription drugs. Therefore, T.C.A. § 53-10-104(b) does not violate the Commerce Clause.

It is the conclusion of this office that out-of-state pharmacies and pharmacists should comply with the provisions of T.C.A. § 53-10-104(b).

V.

Finally, you have asked whether out-of-state pharmacies dispensing prescription drugs by mail to Tennessee residents must comply with all Tennessee laws and rules regarding the dispensing of prescription drugs.

As discussed in the analysis above, the provisions of T.C.A. §§ 63-10-201, et seq. and the regulatory authority of the Tennessee Board of Pharmacy extend to out-of-state pharmacies and pharmacists. Therefore, such pharmacies and pharmacists must comply with the provisions of those statutes, and of other applicable regulations, so long as such laws and rules do not discriminate against or unduly burden interstate commerce.

Sincerely,

Michael Cody

W. J. Michael Cody
Attorney General

John K. Walkup

John Knox Walkup
Chief Deputy Attorney General

Daryl J. Brand

Daryl J. Brand
Assistant Attorney General

DJB:jt
cc: J. Floyd Ferrell, Director
Tennessee Board of Pharmacy

State of California

Memorandum

To : Lorie Garris Rice
Executive Officer
California State Board of Pharmacy
Sacramento

Date October 29, 1984

File No.:

Telephone ATSS 677-2074
(213) 736-2074

From : Office of the Attorney General
LOS ANGELES

Subject: LICENSURE AND REGULATION OF OUT-OF-STATE MAIL ORDER PHARMACIES

You have asked, specifically as it applies to out-of-state mail order pharmacies:

1. Whether the Board may require licensure of such pharmacies
2. Whether the Board may regulate the condition of drugs and devices which are sent into this state by such pharmacies.

The answer to both questions is yes.

CALIFORNIA LAW

Business and Professions Code sections 4084.5 and 4084.6 provide for licensure of out-of-state distributors, including pharmacies, and their agents, who are doing business in California.

Section 4084.6 also provides that issuance of a license pursuant to that section is irrelevant to tax liability issues and is not evidence such a license is doing business in California.1/

Business and Professions Code section 4416 provides that the fee for a pharmacy shall not exceed $300, for a wholesaler $500, and for a 4084.6 licensee $500.

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1. The significance of these provisions is discussed in the next section of this memorandum.

Pursuant to Board regulation 1749, the actual current fees are $200 for a pharmacy and $130 for renewal, $330 for a wholesaler (and $330 for renewal), and $330 for a 4084.6 licensee (and $330 for renewal).

The pharmacy act (Bus. & Profs. Code §§ 4000-4416) and regulations thereunder, the state food and drug act (Health & Safety Code § 26000 et seq.) and the Controlled Substances Act (Health and Safety Code § 11000 et. seq.) contain the major provisions governing packaging, labeling and quality of drugs.

MAIL ORDER PHARMACIES ARE DOING BUSINESS IN CALIFORNIA

"Doing business" in a state varies depending on the state power being asserted and the business being regulated.

Thus when section 4084.6 requires licensure for companies "doing business" in California, it carefully establishes this is something different from doing business for taxation purposes or for the purpose of service of process by stating that "doing business" under section 4084.6 is not the same as "doing business" for taxation or other purposes.

For regulation, the connection between the state and the regulated person must be more substantial than that necessary to establish a basis for personal service. Aldens v. La Follette (1977, 7th Cir) 552 F.2d 745, 751. But what minimum contacts are necessary depend on the state interest being served. For example, while the state interest in regulating, say, greeting cards is minimal, its interest in regulating insurance is substantial and such regulations have been upheld as to purely mail order, out-of- state insurers. People v. United National Life Ins. Co. (1967) 66 Cal.2d 577, app. dism. (1967) 389 U.S. 330.

The state's even greater interest in close regulation of health professions and dangerous drugs hardly needs detailing and would clearly justify finding pharmacies which mail prescriptions into this state are "doing business" here.

THERE IS NO IMPERMISSIBLE BURDEN ON INTER-STATE COMMERCE

The 10th Amendment to the United States Constitution reserves to the States the powers not delegated to the

United States or prohibited to the States. This has repeatedly been interpreted to reserve broad police power as to a state's health, safety and welfare. This is particularly recognized as to health professions, Barsky v. Bd. of Regents (1954) 347 U.S. 442, 449, and pharmaceuticals, People v. Privatera (1979) 23 Cal.3d. 697, cert. den. (1979) 444 U.S. 949

The inter-state commerce clause does not forbid burdens being imposed on inter-state commerce. The burden simply cannot be undue.

The current test of a state regulation's validity is found in Pike v. Bruce Church, Inc. (1970) 397 U.S. 137, 142:

> "Where the statute regulates evenhandedly to effectuate a legitimate, local public interest, and its effects on inter-state commerce are only incidental, it will be upheld unless the burden imposed on such commerce is clearly excessive in relation to the putative local benefits."

Clearly the interest the State seeks to effectuate - public health and safety and close control of drug distribution in this state - is legitimate.

The effects are incidental, in that similar effects accrue to any in-state distributor (license, fee, control of packaging).

As to the burden, what can be tolerated will depend on the nature of the local interest and whether it could be promoted as well with a lesser impact on interstate activities (ibid).

As indicated, concern for competent health care delivery and control of inherently dangerous substances is an interest of the highest order.

Moreover, California is not barring mail order traffic, nor restricting it in any way local licensees are not restricted. It merely requires a license, a minimal fee which is closely related to actual costs and packaging, labeling and quality requirements which have been determined to be necessary for the safety and health of residents of this state.

The only jurisdiction which has directly addressed this issue, has reached the same conclusion. Pharmaceutical Mfrs. Assn. v. New Mexico Bd. of Ph. (1974) 525 P.2nd 931 held:

> "The state interest in drug control is substantial and ever growing. In the present regulatory system that interest is magnified by a corresponding federal interest. The regulations questioned here, and their authorizing statutes are part of a coordinated state-federal drug abuse prevention system." (at 935).

Two Attorney Generals - Ohio and Wisconsin - have rendered opposite opinions on the issue, but the Wisconsin opinion, which is consistent with the New Mexico case, appears to provide the better reasoned analysis, balancing the strong interest of the state in regulating sale of prescription drugs from out-of-state pharmacies to state residents against the incidental effect of the regulation on inter-state commerce. 72 Ops. Atty. Gen. Wisc (1983) 121, 124.

Other cases in many jurisdictions, have upheld a variety of pharmacy-related statutes against inter-state commerce clause attacks. See, for example, Pharmaceutical Soc. of State of N.Y. v. Lefkowitz (1978, 2nd Cir.) 586 F.2d 953 (upholding New York's Generic Drug Law against an Inter-State Commerce challenge).

One United States Supreme Court case, Eli Lilly and Company v. Sav-On-Drugs, Inc. (1961) 366 U.S. 276, has stated that a state cannot require a license for an out-of-state distributor engaged solely in inter-state commerce. But that case did not involve delivery to ultimate users and was not based on an analysis of police powers and public health and safety. Also, the decision was 5-4 and the 5th vote was a concurring opinion which expressly pointed out the question of licensing a wholly inter-state business for regulatory purposes was not being decided. The concurring opinion pointed out that a licensing requirement does not deny the licensee access to in-state customers (at 284, 286).

One state case, State v. Rasmussen (Iowa, 1973) 213 NW2d 661, has held that Iowa cannot bar out-of-state practitioners from having prescriptions filled in Iowa without being licensed in Iowa, even though registered federally to prescribe controlled substances. There are several distinguishing factors from the mail order pharmacy situation, including the volume of the business, the regularity of the business (the Rasmussen court is clearly concerned with the burden of requiring any prescriber who sends even one prescription into Iowa to be licensed beforehand), and the question of solicitation of business, as well as the fact the in-state, licensed pharmacy in the Rasmussen case still had to package, label and dispense the prescription in conformity with state requirements, so there was little direct threat to public health and safety.

It appears the better view is that the action California seeks to take, in light of the goal to be achieved, does not unduly burden inter-state commerce.

THERE IS NO DENIAL OF DUE PROCESS OR EQUAL PROTECTION

As previously noted, through direct solicitation, or use of agents, mail order pharmacies, whether by volume of business, number of transactions and/or expressed as a percentage of the pharmacy's over-all business, have sufficient business contacts with California for California to exercise regulatory control.

Since out-of-state distributors are treated essentially the same as in-state licensees, there is clearly no denial of equal protection.

THERE IS NO PREEMPTION

Where national uniformity of laws is required or where the federal government expressly preempts a field, or the courts find it has, the states will be foreclosed from enforcing independent regulations.

But here there is no preemption.

Clearly, the federal drug laws are intended to set minimum national standards, not uniform requirements. Congress is obviously aware of the extensive state pharmacy and food and drug laws, but the federal law includes no provision limiting state regulation in these areas. In fact, as noted in the Pharmaceutical Mfrs. Assn. case the intent is to have a coordinated state-federal system (at 935).

As to controlled substance law Congress, in 21 United States Code section 903, has expressly authorized states to regulate controlled substances; basically saying state statutes will be upheld unless they are in positive conflict such that the federal and state laws cannot stand together.

Thus the whole scheme of federal regulation in the area of drugs indicates the field has not been preempted from the states.

CONCLUSION

California may enforce its licensure, licensing fee and packaging, labeling and content laws against out-of-state, mail order pharmacies.2/

William L. Marcus
WILLIAM L. MARCUS
Deputy Attorney General

WLM:mpe

cc : J. M. Huntington, AAG, LA
R. F. Russo, DAG, LA

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2. And a similar analysis would apply to other out-of-state distributors.

William J. Guste, Jr.
Attorney General

State of Louisiana
DEPARTMENT OF JUSTICE
Baton Rouge
70804

November 7, 1985

OPINION NUMBER 85-837 Rel. 11-13-85

85-A...PERMITS
86...PHARMACY--STATE BOARD OF

No constitutional fault in Act 216 under either the Commerce Clause of the U. S. Constitution or under any other state or federal constitutional provision, in that no out-of-state pharmacy shall do business in this state unless issued a permit by the Board.

Act 216 of 1985
R.S. 37:1184

Honorable Garey J. Forster
State Representative
District 98
4761 Music Street
New Orleans, Louisiana 70122

Dear Mr. Forster:

You have requested an opinion as to whether Act 216 of 1985 is constitutional. Act 216 amends and reenacts R.S. 37:1184 relative to the Louisiana State Board of Pharmacy. The amendment continues the prior provisions of Section 1184 as Paragraph A of the amended Section, and enacts Paragraph B as a new provision. Section 1184 as amended presently provides:

> §1184. Permits required
> A. No person shall operate, maintain, open, or establish any pharmacy in this state unless he has been issued a permit by the board.
> B. No out-of-state pharmacy shall do business in this state until it has been issued a permit by the board.

The Resume' of the Louisiana Legislature of the 1985 Regular Session merely reflects that Act 216 retained the existing law and ".....further prohibits an out-of-state pharmacy from doing business in the state until it has been issued a permit by the board."

We see no significant difference by the addition of Paragraph B. Prior to the amendment, no person (which would include in-state and out-of-state pharmacies) could operate, maintain, open, or establish, a pharmacy in Louisiana (which would prohibit any pharmacy from doing business in Louisiana) without a permit.

Thus, as we see it, Paragraph B is merely an express restatement of what the existing law impliedly prohibited. We can find no constitutional fault in Act 216 under either the Commerce Clause of the United States Constitution or under any other state or federal constitutional provision.

Very truly yours,

WILLIAM J. GUSTE, JR.
Attorney General

BY: Kenneth C. Dejean
KENNETH C. DEJEAN
Chief Counsel

KCD/lg

The State of Wisconsin
Department of Justice

123 West Washington Avenue
Mailing Address: P.O. Box 7857
Madison, Wisconsin 53707

Bronson C. La Follette
Attorney General

Ed Garvey
Deputy Attorney General

August 23, 1983

OAG 33-83

Ms. Barbara Nichols
Secretary
Department of Regulation and Licensing
1400 East Washington Avenue
Madison, Wisconsin 53708

Dear Ms. Nichols:

The Pharmacy Examining Board has requested my opinion on several questions regarding the application of chapter 450, Stats., which regulates the practice of pharmacy in Wisconsin, to out-of-state pharmacies that regularly and continually solicit mail orders for the retail sale of prescription drugs to Wisconsin residents. The issues presented in your request have been restated below:

1. Does chapter 450 authorize the Pharmacy Examining Board to extend its licensing and registration requirements to out-of-state pharmacies which solicit mail-order sales from Wisconsin residents?
2. Does the regulation of an out-of-state pharmacy by the Wisconsin Pharmacy Examining Board, whether pursuant to a specific statute or based on an implied legislative mandate, establish an unconstitutional burden on interstate commerce?
3. If it is assumed that out-of-state pharmacies may dispense prescriptions by mail to Wisconsin residents without being licensed, must the pharmacies nevertheless comply with the other provisions of chapter 450 regarding the dispensing of prescription drugs?

I have concluded that chapter 450 may be applied to regulate out-of-state pharmacies when they regularly and continually solicit mail-order sales of prescription drugs from Wisconsin residents. Although chapter 450 does not explicitly require out-of-state pharmacists to become licensed or registered in Wisconsin, an implied power to regulate them when they solicit orders from Wisconsin residents may be inferred from the statute. With regard to the second issue, it is my opinion that application of chapter 450 to out-of-state pharmacists does not create an unconstitutional burden on interstate commerce. An opinion on the third issue is not necessary, since I have concluded that out-of-state pharmacies may not dispense prescriptions to Wisconsin residents without being licensed by the state. Therefore, they are compelled to comply with all the other provisions of chapter 450.

Section 450.04(2) provides in part: "No person may sell, give away, barter, compound or dispense drugs, medicines or poisons ... unless he or she is a registered pharmacist ...."

Section 450.07(3) provides: "No person, except a registered pharmacist or a practitioner, shall prepare, compound, dispense or prepare for delivery for a patient any prescription drug."

An analysis of the applicable case law underscores the strong policy considerations in favor of a statutory interpretation which would permit the Pharmacy Examining Board to regulate out-of-state pharmacies when they solicit mail-order sales from Wisconsin residents. As a general proposition, the courts have uniformly held that a state may enact safety regulations under the police power in the interest of the public health and welfare. State v. Wetzel, 208 Wis. 603, 243 N.W. 768 (1932); Bisenius v. Karns, 42 Wis. 2d 42, 165 N.W.2d 377 (1969); see also 16A Am. Jur. 2d Con Law § 417. In more specific terms, the regulation of pharmacies has been recognized as a legitimate exercise of the state's police power to act for the protection of the public health and general welfare. Milligan v. Board of Registration in Pharmacy, 348 Mass. 491, 204 N.E.2d 504 (1965); Harvey v. Peters, 237 Ark. 687, 375 S.W.2d 654 (1964); see also 25 Am. Jur. 2d Drugs, Narcotics and Poisons, §§ 7, 8.

Thus, the Wisconsin Supreme Court has held that the state may, through the exercise of its police power for the protection of the public health, regulate the sale of drugs. The State v. Heinemann, 80 Wis. 253, 49 N.W. 818 (1891); see also State v. Wakeen, 263 Wis. 401, 57 N.W.2d 364 (1953) and Butala v. State, 71 Wis. 2d 569, 239 N.W.2d 32 (1976). These cases refer only to intrastate sales of prescription drugs. Nevertheless, they provide compelling authority for the proposition that Wisconsin's pharmacy laws are designed to "protect the health and lives of citizens throughout the state from improper, dangerous, and destructive compounds, put up by incompetent or inefficient persons." Heinemann, 80 Wis. at 256.

Generally, statutes should be broadly construed in order to effect their legislative purpose. State ex rel., McGrael v. Phelps, 144 Wis. 1, 9, 128 N.W. 1041 (1910). In attempting to discern the legislative purpose behind the pharmacy laws, the Wisconsin Supreme Court has commented that beginning with the first act regulating the practice of pharmacy in 1882, "through the subsequent amendments of 1895 and 1897, which completely prohibited sale by anyone except a registered pharmacist, the legislature placed increasingly greater restrictions and limitations upon the dispensing and compounding of prescriptions and the sale of drugs." State v. Maas, 246 Wis. 159, 163, 16 N.W.2d 406 (1944). Taking into account the historical trend in favor of greater restrictions on the sale of drugs and the obligation to consider the underlying purpose of former statute section 151.04(2) (since renumbered section 450.04(2)), the court in Maas found a violation of the statute when a registered pharmacist allowed an unregistered clerk to dispense drugs. Id. at 159. These same considerations are also important in determining whether sections 450.04(2) and 450.07(3) apply to out-of-state pharmacists.

In Meyers v. Matthews, 270 Wis. 453, 71 N.W.2d 368 (1955), a regulatory statute was held applicable to out-of-state collection agencies which solicited in Wisconsin by mail. The relevant statute in that case was section 218.04(2), which provides that "[n]o person shall operate as a collection agency or as a collector or solicitor in this state without first having obtained a license as required by this section." The court concluded that since the collection agency was doing business with Wisconsin residents through its agents, it was subject to the provisions of section 218.04. Thus, in the case of a statute which did not explicitly refer to "foreign collection agencies," and was just as broad as sections 450.04(2) and 450.07(3), it was held that the statute should nevertheless apply. This suggests that a similar holding would be reached in a situation involving an out-of-state pharmacist.

Having concluded that chapter 450 authorizes the Pharmacy Examining Board to regulate out-of-state pharmacies that transact business with Wisconsin residents, the question remains whether this licensing requirement establishes an unconstitutional burden on interstate commerce.

A threshold inquiry is whether personal jurisdiction over the out-of-state operation has been established. The general standard is that personal jurisdiction is established if the foreign corporation has "minimum contacts" with the forum state. International Shoe Co. v. Washington, 326 U.S. 310 (1945). However, in the case of regulation, "the connection between a state and the regulated person must be of a more substantial character than the 'minimum contacts' needed to support judicial process running against a person." Aldens v. La Follette, 552 F. 2d 745, 751 (7th Cir. 1977). The governing standard in the case of regulatory statutes was enunciated in National Liberty Life Ins. Co. v State, 62 Wis. 2d 347, 215 N.W.2d 26 (1974): "[c]ontacts that would justify regulatory provisions as to one type of business might not as to another because of the greater interest of the state in the former than in the latter. Thus, a State can properly regulate an insurance business based upon contacts which would not support regulation of a greeting card business, for example." Id. at 354 (emphasis in original). Since the state interest in regulating the practice of pharmacy has already been demonstrated as very great, the contacts required to justify regulation of out-of-state pharmacies are necessarily quite minimal.

As stated earlier, state regulations concerning the sale of prescription drugs have been upheld as a valid exercise of the police power to act for the protection of the public health and general welfare. Such regulations are not rendered unconstitutional even though they may indirectly affect interstate commerce since Congress has not expressed an intent to preclude states from entering this area. Pharmaceutical Soc. of New York v. Lefkowitz, 454 F. Supp. 1175 (S.D. N.Y. 1978). I conclude, therefore, that in balancing the strong interest of Wisconsin in regulating the sale of prescription drugs from out-of-state pharmacies to state residents against the incidental effect of the regulation on interstate commerce, there exists no undue burden on such commerce.

It should also be noted that the application of chapter 450 does not discriminate against nonresidents or grant special privileges and immunities to residents. State v. Evans, 130 Wis. 381, 110 N.W. 241 (1907). Since chapter 450 evenly regulates resident as well as nonresident pharmacists, it could not be construed as a discriminatory burden on interstate commerce.

You have also inquired whether out-of-state pharmacists would have to comply with other "dispensing laws" of this state. An opinion on this issue is not necessary since it has already been decided that out-of-state pharmacies must comply with all the requirements of chapter 450. Nevertheless, your inquiry suggests that there may be some venue problems in enforcing the statute. These are briefly discussed below in order to help facilitate enforcement efforts by your Department.

Violation of sections 450.04(2) and 450.07(3) is punishable by fine or imprisonment under sections 450.05(1) and 450.07(12). In a criminal prosecution, venue may be established under section 939.03(1)(a), (b) or (c). In a civil proceeding, personal jurisdiction over a pharmacist located in another state who delivers prescriptions in Wisconsin can be established under section 801.05(4). However, it should be noted that significant practical problems are often presented in enforcing state laws against out-of-state firms. These practical problems should be carefully considered before the Department undertakes enforcement action against an out-of-state pharmacist.

It should also be noted that the out-of-state pharmacist who solicits, prepares, dispenses and delivers would not be the only person in violation of Wisconsin law. A Wisconsin resident who procured such prescription drugs and had them in his or her possession would be in violation of section 450.07(7), which provides: "It is unlawful for any person to have any prescription drug in his or her possession unless such drug was obtained in compliance with this section."

Sincerely yours,

Bronson C. La Follette
Attorney General

BCL:JDJ:RJV:jmm:dah

CAPTION:

Out-of-state pharmacist not registered in Wisconsin is in violation of sections 450.04(2) and 450.07(3), Stats., where he or she on a regular and continuing basis solicits orders for the retail sale of prescription drugs, where preparation is out-of-state and delivery is by mail to patients located in Wisconsin.

THE ATTORNEY GENERAL
OF TEXAS

JIM MATTOX
ATTORNEY GENERAL

16 P 1:39

October 8, 1986

Jerry Hodge, R.Ph.
President
Texas State Board of Pharmacy
211 East 7th Street, Suite 1121
Austin, Texas 78701

Opinion No. JM-555

Re: Whether the State Board of Pharmacy may license and regulate out-of-state mail-order pharmacies

Dear Dr. Hodge:

On behalf of the Texas State Board of Pharmacy you ask the following questions:

> 1. Whether sections 18 and 29 of article 4542a-1, V.T.C.S., authorize the board to license out-of-state pharmacies or pharmacists which solicit mail-order sales of prescriptions from Texas residents.
>
> 2. Whether requiring licensing by the board of out-of-state pharmacies or pharmacists, whether pursuant to a specific statute or based on an implied legislative mandate, establishes an unconstitutional burden on interstate commerce.
>
> 3. If it is assumed that out-of-state pharmacies and pharmacists may dispense prescriptions by mail to Texas residents without being licensed by the board, [whether] the pharmacies or pharmacists [must] nevertheless comply with other provisions of article 4542a-1, V.T.C.S. (Texas Pharmacy Act), article 4476-15, V.T.C.S. (Texas Controlled Substances Act), and article 4476-14, V.T.C.S. (Texas Dangerous Drugs Act), regarding the dispensing of prescriptions drugs.

As a fundamental rule, administrative agencies have only those powers granted by statute and those powers necessarily implied from the statutory authority conferred or duties imposed. City of Sherman v. Public Utility Commission, 643 S.W.2d 681, 686 (Tex. 1983); see also State ex rel. Grimes County Taxpayers Association v. Texas Municipal Power Agency, 565 S.W.2d 258 (Tex. Civ. App. - Houston [1st Dist.] 1978, no writ). You premise your first question specifically on sections 18 and 29 of the Texas Pharmacy Act, article 4542a-1, V.T.C.S. You also cite sections 17 and 19 of the act in your request letter.

Section 17 details the board's responsibilities, in part, as follows:

> (a) The board is responsible for the regulation of the practice of pharmacy in this state, including the following:
>
> (1) the licensing by examination or by reciprocity of applicants who are qualified to engage in the practice of pharmacy and the licensing of pharmacies under this Act;
>
> (2) the renewal of licenses to engage in the practice of pharmacy and licenses to operate pharmacies;
>
> . . . .
>
> (4) the enforcement of those provisions of this Act relating to the conduct or competence of pharmacists practicing in this state and the conduct of pharmacies operating in this state and the suspension, revocation, fining, reprimanding, cancellation, or restriction of licenses to engage in the practice of pharmacy or to operate a pharmacy;
>
> . . . .
>
> (6) the enforcement of this Act and any rules adopted under this Act.
>
> (b) The board has the following responsibilities relating to the practice of pharmacy and to prescription drugs and devices used in this state in the diagnosis, mitigation, and treatment or prevention of injury, illness, and disease:
>
> (1) regulation of the delivery or distribution of prescription drugs and devices, including the right to seize, after notice and hearing, any prescription drugs or devices posing a hazard to the public health and welfare, but the board may not regulate: [certain manufacturing and wholesale exceptions];

> (2) specification of minimum standards for professional environment, technical equipment, and security in the prescription dispensing area; and
>
> (3) specification of minimum standards for drug storage, maintenance of prescription drug records, and procedures for the delivery, dispensing in a suitable container appropriately labeled, or providing of prescription drugs or devices within the practice of pharmacy. (Emphasis added).

Section 19 states, in part, that

> (a) A person may not dispense or distribute prescription drugs unless he is a licensed pharmacist or is authorized by this Act to dispense or distribute prescription drugs. (Emphasis added).

Section 29 provides that

> (a) A pharmacy shall annually register with the board.
>
> . . . .
>
> (d) The board shall establish by rule the standards that each pharmacy and its employees or personnel involved in the practice of pharmacy shall meet to qualify for the licensing or relicensing as a pharmacy in each classification.
>
> . . . .
>
> (f) The board shall have the authority to inspect facilities licensed under this Act for compliance with this Act.

Section 16 adds to section 29(f) by providing for extensive administrative inspections of the physical facilities of pharmacies under the board's jurisdiction.

In light of these provisions, the context of your first question requires consideration of regulation both of "the practice of pharmacy" and of "pharmacies." You do not present any specific administrative rules which explain how the board plans to apply all of these provisions to out-of-state mail-order pharmacies. The legislature intended to grant the board statutory authority, under sections 17 and 19, to regulate the practice of pharmacy by out-of-state pharmacists and pharmacies only to the extent they actually engage in business within the state of Texas. Although this may include annual registration of pharmacies under section 29(a), the legislature could not have intended the board to physically inspect, pursuant to sections 18 and 29(f), facilities located in other states. Thus, this statute permits the board to require that persons who practice pharmacy in Texas be licensed; it does not allow the board to license pharmacies that are located outside of Texas.

Section 17 authorizes the board to regulate the "practice of pharmacy in this state." Section 19 authorizes the board to prohibit persons from engaging unlawfully in the "practice of pharmacy." The "practice of pharmacy" is defined in section 5 of article 4542a-1 as follows:

> (29) 'Practice of pharmacy' means interpreting and evaluating prescription or medication orders, dispensing and labeling drugs or devices, selecting drugs and reviewing drug utilization, storing prescription drugs and devices and maintaining prescription drug records in a pharmacy, advising or consulting when necessary or required by law about therapeutic value, content, hazard, or use of drugs or devices, or offering or performing the services and transactions necessary to operate a pharmacy. (Emphasis added).

Sections 17 and 19 also provide direct authority to regulate the dispensing, distributing, and delivering of prescription drugs. See §§17(b)(1)-(3); 19(a). These terms are defined in section 5 as follows:

> (14) 'Deliver' or 'delivery' means the actual, constructive, or attempted transfer of a prescription drug or device or controlled substance from one person to another, whether or not for a consideration.
>
> . . . .
>
> (16) 'Dispense' means preparing, packaging, compounding, or labeling for delivery a prescription drug or device in the course of professional practice to an ultimate user or his agent by or pursuant to the lawful order of a practitioner.
>
> (17) 'Distribute' means the delivery of a prescription drug or device other than by administering or dispensing. (Emphasis added).

Out-of-state mail-order pharmacists or pharmacies which fill prescriptions for Texas residents clearly deliver, dispense, or distribute those prescriptions in Texas. Consequently, the legislature granted authority in sections 17 and 19 of article 4542a-1 to regulate mail-order sales or transfers of prescription drugs from out-of-state pharmacists or pharmacies to persons within Texas with regard to the aspects of such practice that may directly affect users residing in Texas. See also V.T.C.S. art. 4476-14, §2(b); art. 4476-15, §1.02(8)-(13).

Your second question is whether such regulation would create an unconstitutional burden on interstate commerce. Because you do not present specific administrative rules detailing exactly which aspects of sections 17 and 19 will be applied to out-of-state pharmacies and pharmacists and how those provisions will be applied, this opinion can provide only the general principles of law established in similar cases under the Commerce Clause of the United States Constitution.

The basic criteria for determining the validity of state statutes and actions which affect interstate commerce are set forth in Pike v. Bruce Church, Inc., 397 U.S. 137, 142 (1970), as follows:

> Where the statute regulates evenhandedly to effectuate a legitimate local public interest, and its effects on interstate commerce are only incidental, it will be upheld unless the burden imposed on such commerce is clearly excessive in relation to the putative local benefits. If a legitimate local purpose is found, then the question becomes one of degree. And the extent of the burden that will be tolerated will of course depend on the nature of the local interest involved, and on whether it could be promoted as well with a lesser impact on interstate activities. (Citation omitted).

Authorities in several jurisdictions across the country have considered the constitutionality of different statutory schemes which regulate out-of-state mail-order pharmacists or pharmacies with varying results. Some upheld the constitutionality of their statutes under the Commerce Clause. See, e.g., Pharmaceutical Manufacturers Association v. New Mexico Board of Pharmacy, 525 P.2d 931 (N.M. Ct. App. 1974); Wisconsin Attorney General Opinion No. 33-83 (August 23, 1983); See also 61 Op. Cal. Att'y Gen. 192 (No. CV 76-212, CV 77-236; May 2, 1978). Others have not. See, e.g., Iowa v. Rasmussen, 213 N.W.2d 661 (Iowa 1973); Nebraska Attorney General Opinion No. 57 (April 4, 1985); Ohio Attorney General Opinion No. 82-032 (May 4, 1982). All of these opinions agree, however, that regulation of prescription drugs meets the first part of the constitutional test under the Commerce Clause -- that the regulation must effect a legitimate local interest.

Article 4542a-1, in section 2, recognizes that the practice of pharmacy in this state affects the health, safety, and welfare of the public. The overall purpose of the act is to protect the consumers of prescription drugs. The State Board of Pharmacy also has regulatory duties with regard to controlling drug abuse and misuse under the Texas Controlled Substances Act, article 4476-15, V.T.C.S., and the Texas Dangerous Drugs Act, article 4476-14, V.T.C.S. The regulation of the delivery, distribution, and dispensing of prescription drugs is well within the traditional definition of a state's police power. See Head v. New Mexico Board of Examiners in Optometry, 374 U.S. 424, (1963); Pharmaceutical Manufacturers Association v. New Mexico Board of Pharmacy, 525 P.2d at 931.

In Pike v. Bruce Church, Inc., 397 U.S. at 142, the Court stated that regulation must be evenhanded. The Texas Pharmacy Act is, on its face, even-handed. Under the Commerce Clause, application of the state statute must not discriminate against nonresidents engaged in interstate commerce. See Pike v. Bruce Church, supra; Hunt v. Washington Apple Advertising Commission, 432 U.S. 333 (1977). Because article 4542a-1 applies to both in-state and out-of-state pharmacists and pharmacies, and does not authorize regulations for out-of-state pharmacists and pharmacies which do not apply to those in Texas, it is not per se unconstitutional. See Iowa v. Rasmussen, 213 N.W.2d at 667; Nebraska Attorney General Opinion No. 57, at 4; Ohio Attorney General Opinion No. 82-032, at 5; Wisconsin Attorney General Opinion No. 33-83, at 4.

Nevertheless, even if state regulation of mail-order pharmacists and pharmacies serves a legitimate public interest and is applied evenhandedly, under the test set forth in Pike v. Bruce Church, the burden imposed on interstate commerce by regulation must not outweigh the benefits derived. As quoted above, the court in Pike v. Bruce Church stated that the question is one of degree, depending on the nature of the local interest involved and on whether the interest could be promoted in a less burdensome way. 397 U.S. at 142. The extent of the burden imposed is the analytical point on which legal authorities diverge.

The court in Pharmaceutical Manufacturers Association v. New Mexico Board of Pharmacy characterized the regulations and the licensing fee imposed by the New Mexico statutes as a small burden in relation to the state's interest in drug control. 525 P.2d at 935. The regulations in question were similar to those at issue here insofar as they dealt with regulation of safe storage and labeling of drugs and with the registration or licensing of pharmacists. Similarly, the Wisconsin Attorney General determined that the primary purpose and effect of such regulation is to protect the public.

Because the effect on interstate commerce was merely incidental to this purpose, no undue burden on interstate commerce was found to exist. Opinion No. 33-83, at 4; see also 61 Op. Cal. Att'y Gen. 192.

In contrast, the court in Iowa v. Rasmussen, supra, struck down state regulations which, in practical effect, prohibited Iowa pharmacists from filling prescriptions written by nonresident physicians who were not registered by Iowa authorities. 213 N.W.2d at 663. Clearly, the issue involved here differs. Moreover, the court in Rasmussen declined to rule on whether the local interest involved outweighed the burden imposed, relying instead on a preemption argument. The court cited Huron Portland Cement Co. v. City of Detroit, 362 U.S. 440 (1960), for the proposition that, under the Commerce Clause, state regulation must not disrupt "uniformity" in interstate commerce. 213 N.W.2d at 667. The Rasmussen court concluded that state regulation would prevent uniformity in administering federal registration provisions enacted to control drug trafficking. See also Ohio Attorney General Opinion No. 82-032, at 6.

The court's conclusion with regard to preemption, however, is no longer persuasive. Congress did not intend to preempt the field of drug abuse control:

> No provision of this subchapter shall be construed as indicating an intent on the part of the Congress to occupy the field in which that provision operates, including criminal penalties, to the exclusion of any State law on the same subject matter which would otherwise be within the authority of the State, unless there is a positive conflict between that provision of this subchapter and that State law so that the two cannot consistently stand together. (Emphasis added).

21 U.S.C. §903 (1982). The Texas Pharmacy Act parallels, rather than conflicts with the federal statute. See, e.g., art. 4542a-1, §§5 (10)-(12); 6; see also arts. 4476-14, 4476-15.

The Nebraska Attorney General stated that having to meet the licensing requirements of a number of states would impose a substantial burden on the pharmacies' ability to engage in interstate commerce. Opinion No. 57, pp. 4-5. The opinion stated that

> [i]n such an instance, the pharmacy involved would be subject to multiple licensing procedures, including duplicative registrations, records requirements, and labeling requirements.

Id. The regulations were also deemed to be unnecessarily duplicative because they operated parallel to the federal statutes. The added burden of complying with a duplicative statute regarding the practice of pharmacy, with the "burden" lying primarily in registration and in additional reporting, labeling, and record keeping functions, is not sufficient to outweigh the state's interest in the control of potentially dangerous drugs. If the pharmacy has already created records, it should not be a tremendous "burden" to provide extra copies of those records.

This burden is substantially less onerous than the regulations which have been held unconstitutional by the Supreme Court under the Commerce Clause. For example, in Pike v. Bruce Church, the Supreme Court struck down a statute which stated a primary purpose of promoting and preserving the reputation of Arizona cantaloupe growers by prohibiting deceptive packaging and requiring a certain type of packaging prior to shipment out of state. The parties stipulated that the practical effect of the statute was to compel the company in question to build a packing facility in Arizona. The Court recognized that burdens on commerce which require business operations to be performed in the home state that could more efficiently be performed elsewhere must be viewed with particular suspicion. 397 U.S. at 145; see also Hunt v. Washington Apple Advertising Commission, 432 U.S. 333 (1977); Dean Milk Company v. City of Madison, Wisconsin, 340 U.S. 349 (1951). The Court has upheld a number of ordinances and statutes with burdens of the relatively minor magnitude involved here. See, e.g., Exxon Corporation v. Governor of Maryland, 437 U.S. 117 (1978); Breard v. Alexandria, 341 U.S. 622 (1951); Hartford Accident and Indemnity Co. v. Illinois, 298 U.S. 155 (1936); Asbell v. Kansas, 209 U.S. 251 (1908).

The argument has also been advanced that if a statute is, on its face, for the protection of local economic benefit, then such a statute is per se unconstitutional as an undue burden on interstate commerce. See Iowa v. Rasmussen, 213 N.W.2d at 666-67 (citing Pike v. Bruce Church, 397 U.S. at 145). As indicated, however, article 4542a-1 applies to both in-state and out-of-state pharmacists and pharmacies with regard to the practice of pharmacy; it does not protect local pharmacists.

The purpose of the act is to protect the drug-consuming public; thus the burden on interstate commerce is merely incidental and is outweighed by Texas' interest in controlling the dispensing, distribution, and delivery of prescription drugs. Because you do not present any specific administrative rules which exlain how the board plans to regulate out-of-state mail-order pharmacies and pharmacists, we can only state that regulation by the board of out-of-state pharmacies and pharmacists is not per se unconstitutional under the Commerce Clause. We emphasize that the law requires the least burdensome regulation which will effect the state's objectives. The numerous cases cited in this opinion should provide guidance as to what sorts of regulation have been held to be overly burdensome.

In light of this response to your first two questions, this opinion does not address your third question.

SUMMARY

The Texas State Board of Pharmacy may regulate out-of-state mail-order pharmacists only to the extent that they actually engage in the practice of pharmacy or dispense, deliver, or distribute prescription drugs within the state of Texas. Such regulation is not per se unconstitutional under the Commerce Clause of the United States Constitution.

Very truly yours,

Jim Mattox

JIM MATTOX
Attorney General of Texas

JACK HIGHTOWER
First Assistant Attorney General

MARY KELLER
Executive Assistant Attorney General

RICK GILPIN
Chairman, Opinion Committee

Prepared by Jennifer Riggs
Assistant Attorney General

THE ATTORNEY GENERAL
STATE OF UTAH
DAVID L. WILKINSON
ATTORNEY GENERAL

PAUL M. TINKER
CHIEF DEPUTY ATTORNEY GENERAL
DALLIN W. JENSEN
Solicitor General
DONALD S. COLEMAN, Chief
Physical Resources Division
EARL F. DORIUS, Chief
Governmental Affairs Division
STUART W. HINCKLEY, Chief
Human Resources Division

PAUL M. WARNER
ASSOCIATE DEPUTY ATTORNEY GENERAL
STEPHEN G. SCHWENDIMAN, Chief
Tax & Business Regulation Division
STEPHEN J. SORENSON, Chief
Litigation Division
MICHAEL D. SMITH, Chief
Civil Enforcement Division

March 16, 1987

Mr. David E. Robinson
Director, Division of
Occupational and
Professional Licensing
Heber M. Wells Building
160 East 300 South
Salt Lake City, Utah 84111
BUILDING MAIL

RE: Advertising by out-of-state pharmacies and their agents in Utah. Informal Opinion 87-13

Dear Mr. Robinson:

Several months ago you brought to my attention a concern you had with out-of-state mail order pharmacies doing business in the State of Utah and requested my analysis of the situation. After an initial review, it was determined by this office that the matter receive a more scrutinized review. As such, it was determined to review your request as we do when we issue informal opinions. I have completed my analysis and am issuing my response to your questions as Informal Opinion 87-13.

Utah Code Ann. § 58-17-10(1)(j) (1953), as amended, prohibits any "person" from advertising the filling or refilling of prescriptions for any patient or consumer residing in Utah, unless that person has first been licensed to do so. Thus, under this statutory provision, no person, which by definition includes a company or any other business entity, may lawfully advertise prescription filling or refilling in Utah, if that "person" does not hold a Utah pharmacy license. Only properly licensed pharmacists and licensed pharmacies may lawfully advertise their services in Utah.

The statute makes no distinction between in-state and out-of-state pharmacies. Notably, there is no statutory

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exemption for out-of-state mail order pharmacies. The licensure requirement applies to both out-of-state pharmacies which regularly solicit orders from Utah residents, as well as in-state businesses and pharmacies that desire to advertise their services to the public. By requiring a person to become licensed prior to advertising under Utah Code Ann. § 58-17-10(1)(j), the Utah Legislature is not barring out-of-state mail order pharmacies from doing business in this state, it simply is requiring that the pharmacies become subject to this state's pharmacy regulations in order to effectuate the State's keen interest in protecting the public's health and safety. The licensure requirement also promotes the State's interest in monitoring drug distribution in Utah. Nothing more or less is required of out-of-state pharmacies than is required of in-state distributors. Section 58-17-10(1)(j) thereby applies evenhandedly to all prospective advertisers and distributors of pharmaceuticals whether they are residents or nonresidents of Utah.

The regulation of pharmacies has been recognized as a legitimate exercise of a state's police power. See Milligan v. Board of Registration in Pharmacy, 204 N.E.2d 504 (1964); Harvey v. Peters, 375 S.W.2d 654 (1964). See also: People v. Privatera, 23 Cal.3d 697 (1979), cert. denied, 444 U.S. 949 (1979). Such regulation is consistent with the broad police power which rests with states to ensure the public's health, safety and welfare. Naturally, the operation of a state's police power will, at times, confront the Commerce Clause of the federal Constitution. However, the Commerce Clause only prohibits and invalidates those regulations which place undue burdens on interstate commerce. The current test for evaluating whether a particular state regulation survives scrutiny under the Commerce Clause has been stated by the Supreme Court as:

> Where the statute regulates evenhandedly to effectuate a legitimate, local public interest and its effects on interstate commerce are only incidental it will be upheld unless the burden imposed is clearly excessive in relation to the putative local benefits. Pike v. Bruce Church, Inc., 397 U.S. 137, 142 (1970). (Emphasis added).

It cannot be successfully argued that a state's regulation of pharmacies to monitor the distribution of dangerous drugs to protect the public's health, safety and welfare is not a legitimate governmental objective. It is altogether reasonable that the Utah Legislature would require that all distributors who solicit pharmacy orders and offer pharmacy services to Utah's citizens must be licensed before engaging in these and other related activities, otherwise a state could totally lose control of this important area. The effects of the licensure prerequisite on interstate commerce are incidental since all in-state pharmacies and their representatives must comply with the regulations as well. Unquestionably, Utah Code Ann. § 58-17-10(1)(j) imposes the same requirement on both in-state and out-of-state pharmacies. Therefore, out-of-state pharmacies and their Utah agents are not being singled out and required to adhere to a particular set of guidelines and safeguards, that others need not follow.

Furthermore, just because there is a federal apparatus already in place which regulates controlled substances does not mean that the states are precluded from also entering this area. See Pharmaceutical Soc. of New York v. Lefkowitz, 454 F.Supp. 1175 (S.D.N.Y. 1978). In addressing the issue of federal versus state interests in the control and regulation of drug distribution, the New Mexico court in Pharmaceutical Mfrs. Ass'n v. New Mexico Board of Pharmacy, 525 P.2d 931, 935 (N.M. 1974) held:

> The state interest in drug control is substantial and ever growing. In the present regulatory system that interest is magnified by a corresponding federal interest. The regulations questioned here, and their authorizing statutes are part of a coordinated state-federal drug abuse prevention system.

Here, application of § 58-17-10(1)(j) to out-of-state pharmacies and those Utah businesses which regularly solicit orders from Utah residents does not, in my opinion, create an unconstitutional burden on interstate commerce. After balancing the substantial interest of Utah in regulating the solicitation and sale of prescription drugs from out-of-state pharmacies against the incidental effects of such state regulation on interstate commerce, I conclude there is nothing which violates the Commerce Clause.

With respect to potential claims that § 58-17-10(1)(j)'s application might contravene the principles of due process and equal protection, I also believe that no violation will occur should you choose to enforce this particular provision of Utah's pharmacy law. Either through the use of direct mail solicitation or through the use of agents, mail order pharmacies have established sufficient "contacts" within this state to justify their regulation by an agency such as yours.

Moreover, there is no denial of the equal protection clause, in light of the fact that out-of-state pharmacists are not treated differently than resident pharmacists, but are treated virtually the same.

As mentioned above, Congress, when passing federal regulation drug laws, expressed no intent to preempt the field of government regulation and thereby preclude the states from enforcing their own respective guidelines. In fact, the opposite is true, with a coordinated state-federal system to effectively manage this area of heightening interest being recognized and promoted. See Pharmaceutical Mfrs. Ass'n, supra.

Since the regulation of out-of-state mail order pharmacies does not place a discriminatory burden on commerce and does not violate any other constitutional provision, I believe that application of § 58-17-10(1)(j) constitutes a valid exercise of this state's combined obligation and authority to protect the public's health, safety, and welfare.

Please let me know whether I may be of any further assistance.

Very truly yours,

J. STEPHEN MIKITA
Assistant Attorney General

JSM/lc

NOTE: In conformity with the Attorney General's internal policy on opinions, this informal (letter) opinion does not deal with issues of such broad public import that it would justify detailed scrutiny by the Attorney General Himself or official ~~publication~~ in the manner of a formal opinion. Nevertheless, it is authoritative for the purposes of the agency requesting it, and with respect to the specific questions presented, represents the position of the Attorney General as expressed through his designated staff member.

NARCOTICS & DANGEROUS DRUGS
RECEIVED

JUN 11 1985

Division of Public Health

STATE OF DELAWARE
DEPARTMENT OF JUSTICE
STATE OFFICE BUILDING
820 N. FRENCH STREET, 8TH FLOOR
WILMINGTON, DELAWARE 19801

CHARLES M. OBERLY, III
ATTORNEY GENERAL

DIRECT DIAL:
(302) 571-2523

7 June 1985

Mr. Martin Golden
Chief
Office of Narcotics & Dangerous Drugs
Jesse S. Cooper Building
Dover, Delaware 19901

Re: Regulation of Out-of-State Pharmacies Mailing Prescriptions into Delaware

Dear Marty:

The Board has asked that I review the possibility of regulating pharmacies which are operated out of state but which fill prescriptions for Delaware residents through the mails. In particular, the Board was interested in ascertaining whether we could require such pharmacies to become licensed by the Board under current law.

It is my opinion that the current law would not permit the Delaware Board of Pharmacy to require pharmacies which are operated out of state to obtain a pharmacy permit if such pharmacies mail prescriptions to Delaware residents. My opinion is based upon the wording of 24 Del. C. §2551. That section provides in part "No person shall operate any pharmacy within this State without having first obtained a permit to do so from the Board." The Pharmacy Act's requirement of a separate permit for the operation of a pharmacy clearly is aimed at further regulation of the actual place where prescriptions are dispensed. A pharmacy permit is granted for operation of a pharmacy in a particular place, since section 2551 requires a separate pharmacy permit for each pharmacy if an individual operates more than one pharmacy. In addition, it is my understanding that pharmacy permits are issued to operate a pharmacy at a particular location.

Mr. Martin Golden
Page Two
7 June 1985

Under these circumstances, I believe a pharmacy is operated only at the place where the pharmacy is physically located, regardless of whether drugs are dispensed to out of state destinations. If the Board is interested in pursuing licensure of out of state pharmacies which mail prescriptions to Delaware residents, I would suggest that the Delaware Pharmacy Act be amended to specifically empower the Board to require such pharmacies obtain a pharmacy permit.

Even if legislation where enacted which would specifically require out of state pharmacies to obtain a pharmacy permit prior to dispensing in this State, there are potential legal problems possible. I have spoken preliminarily with Jack Atkinson regarding this matter. Jack informs me that there has been litigation in this area. Pharmacies which may be the subject of regulation have contended that such regulation constitutes an inpermissible infringement on interstate commerce. Jack will be fowarding information regarding this matter. It might be wise for me to discuss it with the Board.

Sincerely,

Edward F. Kafader
Deputy Attorney General

EFK/bac

STATE OF DELAWARE
DEPARTMENT OF JUSTICE
STATE OFFICE BUILDING
820 N. FRENCH STREET, 8TH FLOOR
WILMINGTON, DELAWARE 19801

CHARLES M. OBERLY, III
ATTORNEY GENERAL

DIRECT DIAL:
(302) 571-2529

29 November 1983

Mr. Martin Golden
Chief
Office of Narcotics & Dangerous Drugs
Jesse S. Cooper Building
Dover, Delaware 19901

Re: Licensure of Out-Of-State Pharmacies

Dear Marty:

The Board has asked that I review the Delaware Pharmacy Act with an eye toward possible registration of out-state-pharmacies who fill prescriptions for Delaware residents through the mail. It is my opinion that it would be necessary to seek a legislative change before the Board could require registration of out-of-state pharmacies which dispense drugs to Delaware consumers for ultimate use in Delaware.

If the current Delaware law would allow the Board to require registration of such pharmacies, those requirements would be set forth in Subchapter IV, which deals with the issuance of permits to retail pharmacies. Twenty-four Del. C. §2551 provides that no person shall operate any pharmacy within this State without first having obtained a permit to do so from the Board. Under current Delaware, the Board has the authority to require permits only of those retail pharmacies which operated in this State. Therefore, the Board is unable under current law to require the registration of pharmacies which fill prescriptions for Delaware consumers through the mail.

There is a weak argument that the Board could require the licensing of pharmacists employed by pharmacies which sell drugs to Delaware residents via the mails. Twenty-four Del. C. §2521(b) requires the licensing as a pharmacist of any person who compounds, dispenses or sells a drug. I think it is implicit in section 2521(b) that the compounding, dispensing and selling must occur in the State of Delaware in order for a person to be required to be licensed as a pharmacist. Arguably, the sale of a drug occurs when it is delivered to the consumer. I do not believe that a court would be particularly impressed with such an argument and if the Board is interested in requiring the licensing of those pharmacists who dispense drugs from a pharmacy which delivers drugs through the mail, statutory changes should be sought as well.

If the necessary statutory changes are enacted, I believe there will be a general problem with enforcement of such amendments. I think it will be difficult for the Board to discern that a pharmacy which has failed to register with the Board is selling drugs via the mails to Delaware consumers. I would suggest before the Board contemplates any statutory changes it contact the California Board to see how it is dealing with that problem.

If you have any further questions concerning this matter, please contact me.

Sincerely,

Edward F. Kafader
Deputy Attorney General

EFK/bac

DEPARTMENT OF JUSTICE
STATE OF NEBRASKA
TELEPHONE 402/471-2682 • STATE CAPITOL • LINCOLN, NEBRASKA 68509

ROBERT M. SPIRE
Attorney General
A. EUGENE CRUMP
Deputy Attorney General

April 4, 1985

NO. 57
STATE OF NEBRASKA
OFFICIAL
APR 9 1985
DEPT. OF JUSTICE

Senator Don Wesely
Nebraska State Legislature
1402 State Capitol
Lincoln, NE 68509

Dear Senator Wesely:

This letter is in response to your earlier correspondence in which you requested our opinion as to the constitutionality of LB 578. Specifically, you asked whether LB 578 violates any state or federal constitutional provisions including the Commerce Clause of the United States Constitution. We have reviewed the bill in question along with various relevant legal authorities. As is discussed below, we have concluded that LB 578 is of suspect constitutional validity.

LB 578 would require pharmacies operating outside the State of Nebraska which mail dispensed prescription drugs into the state to obtain a pharmacy license issued by the Nebraska Department of Health. Such pharmacies would also be required to dispense prescription drugs in Nebraska in compliance with Nebraska law governing the practice of pharmacy. The text of the bill, in its entirety, is as follows:

> Any pharmacy operating outside the State of Nebraska which ships, mails, or delivers in any manner a dispensed prescription drug into the State of Nebraska shall hold a pharmacy license issued by the Department of Health, and that part of such pharmacy operation which dispenses prescriptions to Nebraska residents shall comply with Nebraska law, rules, and regulations governing the practice of pharmacy. The Department of Health, upon recommendation of the Board of Examiners in Pharmacy, shall adopt and promulgate rules and regulations,

L. Jay Bartel
John M. Boehm
Dale D. Brodkey
J. Kirk Brown

Timothy E. Divis
Lynne R. Fritz
Ruth Anne E. Galter
Jill Gradwohl
[illegible]

Marilyn B. Hutchinson
Mel Kammerlohr
Sharon M. Lindgren
Charles E. Lowe
[illegible]

Bernard L. Packett
Terry R. Schaaf
LeRoy W. Sievers
Mark D. Starr
John R. Thompson

> including provisions for enforcement, necessary to carry out this section.

The constitutionality of a state's attempt to license or otherwise regulate out-of-state pharmacies which mail prescription drugs into the state has been considered previously by various authorities with differing results. For example, the Attorneys General of Wisconsin and California have indicated that such regulation is consitutionally permissible under the Commerce Clause of the United States Constitution. In contrast, the Attorney General of Ohio has indicated that such regulation is unconstitutional. Given these conflicting authorities, we must proceed with our own independent analysis of your question.

LB 578, by its express language, applies to pharmacies outside the State of Nebraska which ship or otherwise deliver dispensed prescription drugs into the state. Interstate commerce is commerce between the states as opposed to commerce wholly within a state. *Ware & Leland v. Mobile County*, 209 U.S. 405 (1908). Consequently, LB 578 involves an attempt by the State of Nebraska to regulate a form of interstate commerce. There is no question but that the state can subject wholly intrastate commerce to regulation under its police power. However, an attempt to regulate interstate commerce must be tested under the Commerce Clause of the United States Constitution.

The Commerce Clause gives the United States Congress the authority to regulate commerce with foreign nations, among the states, and with the Indian tribes. This authority includes full plenary power to regulate interstate commerce. *In Re Rules and Regulations Nos. 31 and 32*, 193 Neb. 59, 225 N.W.2d 401 (1975). Accordingly, federal statutes passed by Congress pursuant to its powers concerning interstate commerce are capable of preempting any state legislation or regulation of the same subject. *Id*. Therefore, we must first inquire in the present instance as to whether any federal legislation has preempted the state regulation contemplated by LB 578.

In 1970, Congress passed the Drug Abuse Prevention and Control Act, 21 U.S.C. §§801 et seq. The various provisions of that Act comprehensively regulate the distribution and dispensing of controlled substances in interstate commerce throughout the United States. For example, provisions of the Act deal with registration requirements, labeling and packaging of drugs, prescription of controlled substances, and records and reporting requirements. A review of the substantive provisions of that Act would lead to the conclusion that Congress did intend to preempt regulation in this area of interstate commerce. However, §903 of the Act, 21 U.S.C. §903, states:

> No provision of this subchapter shall be construed as indicating an intent on the part of Congress to occupy the field in which that provision operates, including criminal penalties, to the exclusion of any state law on the subject matter which would otherwise be within the authority of the state, unless there is a positive conflict between that provision of this subchapter and that state law so that the two cannot consistently stand together.

This statutory language indicates that Congress did not intend to preempt state regulation of interstate commerce involving controlled substances so long as any state regulation does not directly conflict with the Act itself. Thus, LB 578 is not preempted so long as it does not directly conflict with the federal Act. See, Ranger Division, Ryder Truck Lines, Inc. v. Bayne, 214 Neb. 251, 333 N.W.2d 891 (1983). LB 578 would subject out-of-state pharmacies which mail prescription drugs into Nebraska to the various Nebraska statutes and regulations dealing with the licensing and operation of pharmacies. Our review of those statutes indicates that they largely parallel the provisions of the federal Drug Abuse Prevention and Control Act. Consequently, we do not believe that the Nebraska statutes and the federal law are in direct conflict, and we do not believe that the federal legislation preempts the regulation contemplated by LB 578. We are aware of State v. Rasmussen, 213 N.W.2d 661 (Iowa 1973) in which the Supreme Court of Iowa indicated that parallel Iowa legislation dealing with the registration of nonresident prescribing physicians would, in practical effect, negate the operation of the federal drug act. However, we do not find the Iowa case conclusive in the context of the question presently before us.

The purpose of the Commerce Clause in the United States Constitution is to create an area of trade among the states free from interference by the various states. A & P Tea Company v. Cottrell, 424 U.S. 366 (1976). Therefore, separate and apart from the preemption question, the Commerce Clause acts as a limitation upon the powers of the states even when Congress has not passed federal legislation in a particular area. Id. However, not every exercise of state power is invalid merely because it affects interstate commerce in some way. Id.; Ranger Division, Ryder Truck Lines v. Bayne, supra. The United States Supreme Court has established the following criteria for determining the validity of state statutes affecting interstate commerce:

> Where the statute regulates *evenhandedly* to effectuate a *legitimate local public interest*, and its *effects on interstate commerce are only incidental*, it will be upheld unless the burden imposed on such commerce is clearly excessive in relation to the putative local benefits. If a legitimate local purpose is found, then the question becomes one of degree. The extent of the burden that will be tolerated will of course depend on the nature of the local interest involved, and on *whether it could be promoted as well with a lesser impact on interstate activities*. *Pike v. Bruce Church*, 397 U.S. 137, 142 (1970) (citations omitted) (emphasis added).

It therefore becomes necessary to analyze LB 578 under the criteria established in *Pike v. Bruce Church*.

At the outset, it is apparent that the regulation contemplated by LB 578 serves a legitimate and important local public interest. That regulation directly involves protection of the public health, and is therefore within the most traditional concept of the state's police power. *Head v. Board of Examiners*, 324 U.S. 424 (1963). The state clearly has a strong and legitimate local interest in regulating the manner in which drugs are dispensed to its citizens.

On its face, LB 578 also appears to regulate evenhandedly and in a fashion which does not discriminate against interstate commerce. LB 578 provides that out of state pharmacies dispensing controlled substances within the state must hold a pharmacy license issued by the Department of Health and must comply with Nebraska law governing the practice of pharmacy. Obviously, Nebraska pharmacies in the state operating wholly within intrastate commerce must comply with exactly the same provisions.

We have more difficulty with that portion of the *Bruce Church* criteria which states that the effects of the state regulation on interstate commerce must only be incidental. LB 578 would submit a pharmacy located in another state to Nebraska law concerning licensing and the practice of pharmacy. If that out-of-state pharmacy dispenses drugs through the mail to customers in a number of states, it would seem to us that having to meet the licensing requirement of each particular state would impose a substantial burden upon the pharmacy's ability to engage in interstate commerce. In such an instance, the pharmacy involved would be subject to multiple licensing procedures including duplicative registrations, records requirements, and labeling requirements.

Finally, and most importantly in terms of the present question, the Bruce Church criteria include an evaluation of the local interest involved and an evaluation of whether that interest could be promoted as well in some manner with a lesser impact on interstate commerce. Later cases have interpreted this criterion to encompass a consideration of the consequences to the state if its proposed regulatory action were disallowed, or a consideration of whether a substantial regulatory equivalent is available to the state. A & P Tea Company v. Cottrell, supra; Dixie Dairy Company v City of Chicago, 538 F.2d 1303 (7th Cir. 1976).

Our research in the present instance indicates that the federal Drug Abuse Prevention and Control Act of 1970 extensively regulates pharmacies which dispense controlled substances within the United States along with the various practices involved in dispensing those controlled substances. For example, federal regulations require persons dispensing controlled substances to register with the United States Department of Justice. 21 C.F.R. §1301.21. Federal regulations establish labeling and packaging requirements for controlled substances. 21 C.F.R. §1302.03. Federal regulations establish various requirements for the maintenance of records involving dispensation of drugs and inventories of controlled substances. 21 C.F.R. §1304.24. Federal regulations provide that prescriptions for controlled substances may only be filled by a professional pharmacist. 21 C.F.R. §1306.06. Our review of the various Nebraska statutes dealing with the practice of pharmacy which would apply to pharmacies located out of the State of Nebraska under the provisions of LB 578 indicates that those pharmacy provisions substantially duplicate the provisions of the federal act. Consequently, even though the state admittedly has an important public interest in regulating the dispensing of controlled substances, it seems to us that the existing federal statutes are substantially equivalent to the Nebraska statutes. In addition, the existing federal statutes protect the state's interests so that the consequences to the state are minimal if its attempt to regulate out-of-state pharmacies under the provisions of LB 578 is disallowed. Given the federal statutory framework, the state's regulatory interest under LB 578 is simply not great enough to justify the burden which that bill would place upon interstate commerce. Therefore, LB 578 is of suspect constitutional validity under the criteria established in *Pike v. Bruce Church*, *supra*.

We are aware of *Pharmaceutical Manufacturers Association v. New Mexico Board of Pharmacy*, 86 N.M. 471, 525 P.2d 931 (1974), where the Court of Appeals of New Mexico held that state pharmacy regulations requiring registration by out-of-state sellers and shippers of dangerous drugs were constitutional under the Commerce Clause. We would simply note that the burden on interstate commerce created by registration in that case was substantially less than the burden imposed by licensing under LB 578. We would also note, as discussed earlier, that the various authorities are in conflict on this issue.

One final matter remains. The United States Supreme Court has indicated that state attempts to regulate interstate commerce which may be considered as simple economic protectionism are virtually invalid *per se*. *Philadelphia v. New Jersey*, 417 U.S. 617 (1978). In the present instance, no such economic protectionism is apparent from the plain language of LB 578. However, if LB 578 could be considered as an attempt to protect pharmacies located within the State of Nebraska from competing pharmacies located out-of-state, then LB 578 would be a form of economic protectionism invalid under the United States Constitution.

In summary, we do not believe that LB 578 is preempted by the federal legislation controlling the flow of controlled substances within interstate commerce. However, while we feel that the state has legitimate and strong interest in regulating the process of dispensing drugs, we believe that the regulation envisioned by LB 578 is more than an incidental burden on interstate commerce, and that the state's interest in regulating the flow of controlled substances is adequately protected by the pertinent federal statutes. Consequently, it is our opinion that LB 578 is of suspect constitutional validity under the Commerce Clause of the United States Constitution.

Sincerely yours,

ROBERT M. SPIRE
Attorney General

A. Eugene Crump

A. Eugene Crump
Deputy Attorney General

AEC:bmh
cc: Patrick J. O'Donnell
Clerk of the Legislature

STATE OF KANSAS

OFFICE OF THE ATTORNEY GENERAL

2ND FLOOR, KANSAS JUDICIAL CENTER, TOPEKA 66612

ROBERT T. STEPHAN
ATTORNEY GENERAL

MAIN PHONE (913) [illegible]
CONSUMER PROTECTION [illegible]
ANTITRUST [illegible]

July 20, 1984

ATTORNEY GENERAL OPINION NO. 84-71

Lynn E. Ebel
Attorney, Kansas Board of Pharmacy
Davis, Davis, McGuire & Thompson
P.O. Box 69
400 Shawnee Street
Leavenworth, Kansas 66048

Re: Public Health -- Examination and Registration of Pharmacists -- Registration of Out of State Pharmacists Doing Business in Kansas

Synopsis: The requirements of the Kansas Pharmacy Act, K.S.A. 65-1601 _et seq_ extend to all persons within or without the state who deliver prescription drugs in Kansas. Cited herein: K.S.A. 65-1636, K.S.A. 1983 Supp. 65-1626, 65-1631, 65-1643.

* * *

Dear Ms. Ebel:

As counsel for the Kansas Board of Pharmacy, you request our opinion regarding the authority of the board to require out of state pharmacies doing business in Kansas to hold Kansas pharmacy licenses and be subject to the board's regulations.

K.S.A. 65-1636 is contained in the Kansas Pharmacy Act, K.S.A. 65-1625 et seq., and provides:

> "Except as otherwise provided in this act, the sale and distribution of drugs shall be limited to pharmacies operating under registrations as required by this act and the actual sale or distribution of drugs shall be made by a registered pharmacist or other person acting under his or her immediate personal direction and supervision."

K.S.A. 1983 Supp. 65-1626(i) states that to "distribute means to deliver . . . any drug." Subsection (g) states that to "dispense means to deliver prescription medication to the ultimate user pursuant to the lawful order of a practitioner."

The term pharmacy is defined at K.S.A. 1983 Supp. 65-1626(s) as "premises, laboratory, area or other place (1) where drugs are offered for sale, where the profession of pharmacy is practiced and where prescriptions are compounded and dispensed . . ." As noted above, only pharmacies operating under the direction of a registered pharmacist may distribute drugs in Kansas under K.S.A. 65-1636. K.S.A. 1983 Supp. 65-1643(f) provides that it is unlawful for "any person operating a store or place of business to sell, offer for sale or distribute any drugs to the public without first having obtained a registration or permit from the board . . ."

In none of the foregoing statutes is there any language of limitation which suggests that only Kansas residents are subject to the board's control. Rather, Kansas statutes provide for the registration on a reciprocal basis of out of state pharmacists without examination. K.S.A. 1983 Supp. 65-1631(d). We therefore conclude that the language of the Kansas Pharmacy Act does not suggest that its provisions are limited to pharmacies within this state.

A consideration of the purpose of the act also suggests that there was no intent to limit the application of the act. The state's interest in establishing and maintaining high standards in the dispensation of prescription drugs is clear. *See, e.g., State ex rel. v. Fadely,* 180 Kan. 652, 665 (1957). We therefore conclude that both the language and purpose of the Kansas Pharmacy Act require that out of state pharmacies doing business in Kansas hold a Kansas pharmacy license and be subject to all Kansas regulations.

Very truly yours,

Robert T. Stephan

ROBERT T. STEPHAN
Attorney General

Kenneth R. Smith
Assistant Attorney General

RTS:JEF:KRS:may

State of Ohio
Office of the Attorney General

William J. Brown
Attorney General

Bruce J. Rakay
First Assistant Attorney General
Alex Shumate
Executive Assistant Attorney Gene
James R. Rishel
Chief Counsel
Joel S. Taylor
General Counsel

MAY 04 1982

OPINION NO. 82 032

Franklin Z. Wickham, Executive Director
Ohio State Board of Pharmacy
65 South Front Street, Room 504
Columbus, Ohio 43215

Dear Sir:

I have before me your request for my opinion concerning the operation of mail order retail pharmaceutical distributors. You state in your request that these distributors "operate from one or more central locations, located in one or more states, but they generally dispense or distribute through the mail a number of prescription drugs and pharmaceuticals, most of which are 'dangerous drugs' within the meaning of the Ohio Revised Code." In your request, you mention two different ways in which these distributors have contact with the state of Ohio. First, you state that these distributors advertise in Ohio, "sometimes through agents located and residing in Ohio." These advertisements encourage consumers to place their prescriptions for drugs (such prescriptions being written in most instances by Ohio prescribers) in the mail. The drugs are then mailed directly to consumers. The second way in which these distributors have contact with Ohio is that several distributors have contracted with third party payors in Ohio (such as the Public Employees' Retirement System) "to provide these third-party payors and their beneficiaries with prescription drugs," for which the third-party payors directly pay the distributors.[1]

Your specific questions regarding these distributors are as follows:

> (1) Is the solicitation of orders and mailing of dangerous drugs to residents of the state of Ohio, the "sale" of drugs in the state of Ohio within the meaning of Section 4729.28 of the Revised Code; and, as such, subject to regulation by this Board?
>
> (2) Are the activities of mail order retail pharmaceutical distributors, in advertising and promoting their retail goods through the mails to Ohio consumers, "advertising" within the meaning of Section 4729.36 of the Revised Code; and, as such, subject to regulation by this Board?

Your final question may be restated as follows:

> (3) Is a third-party payor who, pursuant to a contract with a mail order retail pharmaceutical distributor, pays the distributor for "dangerous drugs" provided to the third-party payor's beneficiaries, a "purchaser" of dangerous drugs who must be licensed as a "terminal distributor of dangerous drugs" pursuant to R.C. 4729.54?

With respect to your first two questions, an examination of the concept of "interstate commerce" and the extent to which interstate commerce may be regulated by the individual states is necessary before R.C. 4729.28 and R.C. 4729.36 can fully be analyzed. The first relevant inquiry is whether the mail order retail pharmaceutical distributors described above are engaged in interstate commerce, or whether they are engaged in intrastate commerce, or "doing business" in Ohio. *See generally* R.C. 1703.02 (excepting corporations engaged in Ohio solely in interstate commerce from R.C. Chapter 1703, which regulates foreign corporations doing business in Ohio); R.C. 1703.03 (requiring foreign corporations doing business in Ohio to obtain a license from the Secretary of State).

Whether a corporation is engaged in interstate commerce or intrastate commerce is largely a factual determination, which is dependent on the totality of relevant circumstances surrounding the corporation's business operations. *See* 1936 Op. Att'y Gen. No. 5652, vol. II, p. 769. It is well-established, however, that a person or corporation located in one state who contracts for the shipment of his goods into another state is engaged in interstate commerce. *See* *Strong, Cobb & Co. v. United States*, 103 F.2d 671 (6th Cir. 1939) (the shipment of cold tablets from Ohio to Oklahoma was a shipment in interstate commerce, even though the tablets were shipped in bulk, to be repackaged by the consignee before retail distribution); *United States v. Tucker*, 188 F. 741, 743 (Dist. Ct. S.D. Ohio 1911) ("[a] sale, the parties to which are from different states, when such sale necessarily involves the transportation of goods, is a transaction of interstate commerce. . ."); *Toledo Commercial Co. v. Glen Manufacturing Co.*, 55 Ohio St. 217, 45 N.E. 197 (1896) (the sale and delivery in one state of goods manufactured in another state is interstate commerce); *Golden Dawn Foods v. Cekuta*, 1 Ohio App. 2d 464, 205 N.E.2d 121 (Trumbull County 1964) (the sale and delivery of merchandise to Ohio retail outlets by a foreign corporation was interstate commerce); *Local Trademarks Inc. v. Derrow Motor Sales Inc.*, 120 Ohio App. 103, 201 N.E.2d 222 (Defiance County 1963) (a foreign corporation which sold its goods manufactured outside of Ohio to Ohio firms through traveling agents was engaged in interstate commerce). *See also* *Eli Lilly & Co. v. Sav-on-Drugs Inc.*, 366 U.S. 276 (1961); *Manhatten Terrazzo Brass Strip Co. v. A. Benzing & Sons*, 38 Ohio L. Abs. 353, 50 N.E.2d 570 (App. Franklin County 1943); *Maryland Casualty Co. v. Explosive Sales Co.*, 14 Ohio L. Abs. 491 (App. Mahoning County 1933); *McClarran v. Longdin-Brugger Co.*, 24 Ohio App. 434, 157 N.E. 828 (Wayne County 1926). It is clear from the principles enunciated in these cases that, under the facts you have provided, the retail pharmaceutical distributors, which are foreign corporations and which sell drugs though the mails, such drugs being shipped from another state for delivery in Ohio, are engaged in interstate commerce.

The fact that the distributors are advertising their interstate trade in Ohio does not change the character of the business from interstate to intrastate commerce, even though such advertising is placed by the companies' agents who are located in Ohio. Those acts of a corporation which are incidental yet essential to the corporation's interstate commerce will also be considered interstate commerce. See York Manufacturing Co. v. Colley, 247 U.S. 21 (1918); 1936 Op. No. 5652. See also 1948 Op. Att'y Gen. No. 3566, p. 412 (a foreign corporation, whose purpose was to purchase, hold, and sell real property was not doing business in Ohio by acquiring real estate in Ohio); 1936 Op. No. 5652 (a foreign corporation which maintained an office in Ohio, kept its books and held meetings in Ohio, and received rental payments at its Ohio office, was not doing business in Ohio since all of these acts were essential and incidental parts of its interstate business). Advertising can clearly be seen as an incidental yet necessary part of a corporation's ordinary business. Indeed, the solicitation of interstate business has itself been held to be part of interstate commerce. Memphis Steam Laundry Cleaner Inc. v. Stone, 342 U.S. 389 (1952); Robbins v. Taxing District of Shelby County, 120 U.S. 489 (1887). Merely because the corporation is advertising its interstate business in Ohio does not mean it is "doing business" in Ohio. See Eli Lilly & Co. v. Sav-on-Drugs Inc.; Robbins v. Taxing District of Shelby County; Toledo Commercial Co. v. Glen Manufacturing Co.; McClarran v. Longdin-Brugger Co.

While a corporation which is engaged in interstate commerce may also be doing business within a state, and thus subject to state regulation concerning those intrastate activities, Eli Lilly & Co. v. Sav-on-Drugs Inc., you have provided me with no facts which would indicate that the distributors about which you have inquired are involved in any purely intrastate activity. Thus, I conclude that the mail order retail pharmaceutical distributors described in your letter are engaged solely in interstate commerce, both in their direct solicitation of Ohio consumers, and in their contracts with Ohio third-party providers.[1]

The next relevant inquiry is whether the state has the power to regulate the mail order distributors, even though they are engaged solely in interstate commerce. The Commerce Clause, U.S. Const. art. I, §8, the purpose of which is to facilitate free trade among the states, Dayton Power and Light Company v. Lindley, 58 Ohio St. 2d 465, 391 N.E.2d 716 (1979), confers upon the United States Congress the power to regulate interstate commerce. Notwithstanding the Commerce Clause, the states have the power to regulate matters of local concern which unavoidably involve some regulation of interstate commerce, if Congress has not exercised its powers with regard to such matters. See California v. Thompson, 313 U.S. 109 (1941). If Congress has exercised its power, however, the relevant inquiry is whether the federal regulation preempts further state regulation. See Southern Pacific Co. v. State of Arizona, 325 U.S. 761 (1945); Glenwillow Landfill Inc. v. City of Akron, 485 F.Supp. 671 (N.D. Ohio 1979), aff'd sub nom. Hybud Equipment Corp. v. City of Akron, 654 F.2d 1187 (6th Cir. 1981).

Acting pursuant to the power conferred upon it by art. I, §8, Congress has extensively regulated the interstate flow of controlled substances by enacting the Federal Controlled Substances Act of 1970, tit. II, 84 Stat. 1242 (codified in scattered sections of 18, 21, 42 U.S.C). 21 U.S.C. §801 states in part:

---

[1] Although a corporation may not be considered "doing business" within Ohio for purposes of R.C. Chapter 1703 (regulating foreign corporations) and other state regulatory provisions, it may still be subject to personal jurisdiction in Ohio under this state's long arm statute. See R.C. 2307.382; McCormick v. Haley, 29 Ohio Misc. 97, 279 N.E.2d 642 (C.P. Franklin County 1971).

> The Congress makes the following findings and declarations:
>
> . . .
>
> (3) A major portion of the traffic in controlled substances flows through interstate and foreign commerce. Incidents of the traffic which are not an integral part of the interstate or foreign flow, such as manufacture, local distribution, and possession, nonetheless have a substantial and direct effect upon interstate commerce because—
>
> (A) after manufacture, many controlled substances are transported in interstate commerce,
>
> . . .
>
> (C) controlled substances possessed commonly flow through interstate commerce immediately prior to such possession.
>
> . . .
>
> (5) Controlled substances manufactured and distributed intrastate cannot be differentiated from controlled substances manufactured and distributed interstate. Thus, it is not feasible to distinguish, in terms of controls, between controlled substances manufactured and distributed interstate and controlled substances manufactured and distributed intrastate.
>
> (6) Federal control of the intrastate incidents of the traffic in controlled substances is essential to the effective control of the interstate incidents of such traffic.

Acting on these findings, the Congress has passed a comprehensive system of registration and regulation. For example, pursuant to 21 U.S.C. §822(a), "[e] very person who manufactures, distributes, or dispenses any controlled substance or who proposes to engage" therein, must register with the United States Attorney General. *See* 21 U.S.C. §823 (setting out the registration requirements for manufacturers and distributors of controlled substances). *See also* 21 U.S.C. §841. Registrants are subject to various regulations. *See, e.g.,* 21 U.S.C. §822(f) (inspection of a registrant's or applicant's establishment); 21 U.S.C. §825 (labeling and packaging); 21 U.S.C. §827 (recordkeeping). *See also* 21 U.S.C. §842; 21 U.S.C. §843.

Of particular significance to the issue of whether the federal regulations have preempted further state regulation, however, is 21 U.S.C. §903, which reads:

> No provision of this subchapter shall be construed as indicating an intent on the part of Congress to occupy the field in which that provision operates, including criminal penalties, to the exclusion of any State law on the same subject matter *which would otherwise be within the authority of the State*, unless there is a *positive conflict between that provision of this subchapter and that State law so that the two* *cannot consistently stand together*. (Emphasis added.)

Thus, Congress has indicated that the state may still continue to regulate those matters concerning controlled substances properly within their jurisdiction, unless such regulation is inconsistent with federal regulation. While no federal or Ohio court has interpretated this particular provision, at least one state court has held that to the extent that the federal government has acted with regard to the interstate dispensing of controlled substances, a state is preempted from imposing additional requirements on out-of-state prescribers. State v. Rasmussen, 213 N.W.2d 661 (Iowa 1973). The court in Rasmussen recognized the state's power to regulate intrastate transactions which would complement the federal government's scheme of regulation, but noted that state regulation of those aspects of interstate transactions already controlled by the federal government would in practical effect negate the operation of the federal act. Accordingly, the court concluded that state regulation, with regard to the registration of out-of-state prescribers, was in positive conflict with federal regulation so that the two could not stand together, and thus the state was preempted by 21 U.S.C. §903 and U.S. Const. art. VI, cl. 2, the Supremacy Clause, from requiring the registration of out-of-state prescribers.

Even if a court with jurisdiction to decide this question in Ohio would not adopt the reasoning in Rasmussen and would not find that Ohio was preempted from regulating those aspects of interstate drug transactions already subjected to federal regulation, such court would have to consider whether the Commerce Clause would otherwise prohibit the state from acting in this situation to regulate the mail order distributors. In considering whether a state regulation is inconsistent with the Commerce Clause, it must be determined: whether the regulation serves a legitimate local purpose; whether the statute regulates evenhandedly with only incidental effects on interstate commerce; whether the local purpose justifies the regulation's impact on interstate commerce; and whether the regulation affects an area which requires a uniform national policy. See Pike v. Bruce Church Inc., 397 U.S. 137 (1970); Glenwillow Landfill Inc. v. City of Akron; Panhandle Eastern Pipe Line Co. v. P.U.C., 56 Ohio St. 2d 334, 383 N.E.2d 1163 (1978).

The specific statutes about which you have inquired are part of the state's attempt to regulate the sale and possession of dangerous drugs by imposing a series of licensure requirements, and other restrictions, on persons engaged in the distribution of dangerous drugs. Before considering any specific statutes, therefore, I believe certain general observations are warranted.

State regulation of the filling of Ohio consumers' prescriptions undoubtedly serves a legitimate local purpose. Ohio clearly has the power to protect its citizens' health, life, and safety, and may pass statutes which carry out this power, even though such legislation indirectly affects interstate commerce. See Head v. New Mexico Board of Examiners in Optometry, 374 U.S. 424 (1963). See also California v. Thompson. Moreover, the provisions set forth in R.C. Chapter 4729 appear to be evenhanded in their intended application and do not appear to discriminate against foreign corporations. See Head v. New Mexico Board of Examiners in Optometry; Pike v. Bruce Church Inc.; Dayton Power and Light Company v. Lindley. However, even though state regulation of mail order pharmaceutical distributors serves a legitimate public interest and is evenhandedly applied, it appears that the burden certain regulations would impose on interstate commerce could outweigh the benefits derived therefrom. "Regulation rises to the level of an undue burden if it may seriously interfere with or 'impede substantially' the free flow of commerce between the states" (citation omitted). Panhandle Eastern Pipe Line Co. v. P.U.C., 56 Ohio St. 2d at 339, 383 N.E.2d at 1166. For example, the interstate business of a mail order company is almost certainly to be "impeded substantially" if the company is forced to meet licensure requirements in fifty different states, although other regulations which have a less substantial impact on interstate commerce may be permissible under the Commerce Clause. See Pike v. Bruce Church Inc.

The fourth requirement under the Commerce Clause analysis focuses on the need for uniformity of regulation. A state may not act where uniformity of regulation is essential to the functioning of interstate commerce. See Southern Pacific Co. v. Arizona; Panhandle Eastern Pipe Line Co. v. P.U.C. As noted above, the federal Congress has recognized this need, and has extensively legislated in this area, with the expectation of producing an efficient and uniform scheme for the regulation of controlled substances moving through interstate commerce. While Congress has acted to regulate controlled substances which move in interstate commerce, the state still has the power to control the distribution and dispensing of drugs in Ohio pursuant to R.C. Chapter 4729. Taken together, these acts effectively control the manufacture and distribution of controlled substances and protect consumers, yet still permit the free movement of goods between the states. To allow the various states to impose their own system of regulation of interstate commerce would arguably destroy the purpose behind the Federal Controlled Substances Act. It may be argued that this need for uniformity, as demonstrated by the federal act, outweighs the state's local interest in controlling the distribution of drugs outside the state, especially in light of the fact that the federal act is designed to provide protection to consumers, such protection being the basis of the state's interest in regulation. See State v. Rasmussen.

With these constitutional principles in mind, I turn now to your specific questions. The dispositive inquiry in each case will be whether the General Assembly intended the specific statute to be applicable to persons engaged solely in the interstate distribution of dangerous drugs. Of overriding significance to any such analysis will be R.C. 1.47(A), which provides that "[i]n enacting a statute, it is presumed that compliance with the constitutions of the state and of the United States is intended. . . ."

You have asked whether mail order retail pharmaceutical distributors which solicit orders and mail dangerous drugs to residents of Ohio are engaged in the sale of drugs in Ohio within the meaning of R.C. 4729.28. This section reads: "No person who is not a registered pharmacist or a pharmacy intern under the personal supervision of a registered pharmacist shall compound, dispense, or sell drugs, dangerous drugs, and poisons." R.C. 4729.28, if applied to out-of-state retailers, would absolutely prohibit the companies' sales of drugs to Ohio residents. It is my understanding that the retailers in question are corporations rather than natural persons. Only a natural person or individual may become a registered pharmacist. See R.C. 4729.08 (requiring an applicant for registration as a pharmacist to be a citizen of the United States, of good moral character and habits, a graduate of an approved school or college of pharmacy, and eighteen years old). See also 1981 Op.

Att'y Gen. No. 81-055. Obviously, a corporation could never be registered in Ohio as a pharmacist, and thus foreign corporate retailers could never be in compliance with R.C. 4729.28. Such an absolute prohibition on the retailers' interstate sales in Ohio clearly places an impermissible burden on the flow of interstate commerce, and thus R.C. 4729.28 may not constitutionally be interpreted as applicable to foreign retail distributors who sell their drugs to Ohio consumers.

I note that based upon the foregoing analysis even an Ohio corporation would be prohibited from selling drugs, if R.C. 4729.28 were the sole relevant statute. A more appropriate focus of inquiry with regard to the registration of corporations engaged in the distribution of drugs appears to be R.C. 4729.51(C), which provides that "[n]o person, except a licensed terminal distributor of dangerous drugs or a practitioner shall purchase for the purpose of resale, possess for sale, or sell, at retail, dangerous drugs." R.C. 4729.51(C), therefore, implicity authorizes a "licensed terminal distributor of dangerous drugs" to possess and sell dangerous drugs, and accordingly, provides an express exception to the broad prohibition set out in R.C. 4729.28. To fully respond to your inquiry, I must, therefore, consider whether the General Assembly intended this latter statute to be applicable to foreign distributors.

A "terminal distributor of dangerous drugs" is defined in R.C. 4729.02(Q) as:

> a person other than a practitioner who is engaged in the sale of dangerous drugs at retail, or any person other than a wholesale distributor or a pharmacist who has in his possession, custody, or control dangerous drugs for any purpose other than for his own use and consumption, and includes pharmacies, hospitals, nursing homes, and laboratories,and all other persons who procure dangerous drugs for sale or other distribution by or under the supervision of a pharmacist or medical practitioner.

For the purposes of this definition the term "person" includes a corporation. R.C.4729.02(S). A corporation or other person may obtain a license as a terminal distributor of dangerous drugs pursuant to R.C. 4729.54 if he meets the licensure requirements set forth in R.C. 4729.55. R.C. 4729.51(E), however, provides that a licensed terminal distributor of dangerous drugs must obtain a license for each place or establishment where dangerous drugs are sold, distributed, maintained, controlled, or in the possession or custody of the applicant or licensee. Thus, if out-of-state mail order distributors were found to be subject to regulation under R.C. 4729.51(C) and R.C. 4729.54, they would have to obtain a license for the physical location, which is outside the state of Ohio, from which their drugs are actually distributed. As discussed previously, however, to require a retailer to obtain licenses from the various states into which it ships its goods will almost certainly impede its interstate business. Moreover, the state's legitimate interest in regulating distributors of dangerous drugs is lessened in the instance of the interstate distributor because there is extensive federal regulation in this area and because the distributor is not maintaining possession or custody of the drugs in this state. I note that the licensure requirements set forth in R.C. 4729.55 deal primarily with concerns which are applicable only to facilities at which drugs are kept. For example, pursuant to R.C. 4729.55, an applicant for a terminal distributor's license must demonstrate that he is equipped as to land, buildings, and equipment to properly carry on the business, and that a pharmacist or practitioner will supervise and control the possession and custody of the dangerous drugs maintained by the applicant. Since a mail order distributor never maintains custody of the drugs in this state, certain of the standards set forth in R.C. 4729.55 would have little relevance if applied to such distributors. Accordingly, consistent with R.C. 1.47(A), I must conclude that the General Assembly intended R.C. 4729.51(C) and R.C. 4729.54 to apply only to persons who are selling and otherwise distributing dangerous drugs from establishments located within the state.

Your second question asks whether the activities of the mail order retail pharmaceutical distributors in advertising and promoting their goods to Ohio consumers may be regulated by the Pharmacy Board pursuant to R.C. 4729.36, which reads:

> (A) No place except a pharmacy shall display any sign or advertise in any fashion, using the words "pharmacy," "drugs," "drug store," "drug store supplies," "pharmacist," "druggist," "pharmaceutical chemist," "apothecary," "drug sundries," "medicine," or any of these words or their equivalent, in any manner.
>
> (B) A pharmacy or pharmicist making retail sales may advertise by name or therapeutic class the availability for sale or dispensing of any dangerous drug provided such advertising contains a brief statement of the use and a warning of the specific harms resulting from abuse of such dangerous drug and if such advertisement also includes price information as defined in division (N) of section 4729.02 of the Revised Code.

The applicability of R.C. 4729.36 to out-of-state mail order distributors depends initially on whether such distributors fall within the meaning of the term "pharmacy." If a mail order distributor is not a "pharmacy," R.C. 4729.36(A) would absolutely prohibit a mail order distributor from advertising its interstate business. Because, as discussed above, the solicitation of an interstate business is itself interstate commerce, even when accomplished through the use of local agents, R.C. 4729.36 would act as an absolute restraint on interstate commerce, and thus, would be impermissibly applied in such situation. If, on the other hand, a mail order distributor falls within the definition of a "pharmacy," R.C. 4729.36 does not prohibit advertising by such distributor, it merely subjects such distributor to the requirements set forth in R.C. 4729.36(B).

The term "pharmacy" as used in R.C. 4729.36 means a "place of business. . .where prescriptions are filled or where drugs [or] dangerous drugs. . .are compounded, sold, offered, or displayed for sale, dispensed, or distributed to the public." R.C. 4729.02(A). This definition of "pharmacy" appears sufficiently broad to include mail order distributors. Accordingly, it is necessary to determine whether the conditions on advertising set forth in R.C. 4729.36(B) may constitutionally be applied to foreign mail order distributors.

Division (B) of R.C. 4729.36 requires pharmacies and pharmacists to include in their advertising of dangerous drugs a statement of the use of the drug, a warning of the drug's harms, and price information. The Federal Controlled Substances Act contains no provision regulating the advertisement of drugs moving in interstate commerce. Thus, there is no federal preemption of such advertising, and the states are free to impose their own regulations, as long as interstate commerce is not unduly burdened thereby. It does not appear that the minimal information required by R.C. 4729.36(B) to be in a pharmacy's advertisements would constitute an impermissible burden. An out-of-state retailer is not absolutely prohibited from advertising. He need only be sure that certain information is provided in advertisements which are sent into Ohio if the advertisement mentions a dangerous drug by name or therapeutic class. Thus, I conclude that out-of-state distributors may advertise their interstate business in Ohio, subject to the requirements of R.C. 4729.36(B).

I now turn to your final question as to whether third-party payors who pay pharmaceutical retailers for drugs provided to the payors' beneficiaries are "purchasers" of dangerous drugs who must be licensed as "terminal distributors" pursuant to R.C. 4729.54. As noted previously, R.C. 4729.02(Q) defines a "terminal distributor of dangerous drugs" as

> a person other than a practitioner who is engaged in the sale of dangerous drugs at retail, or any person other than a wholesale distributor or a pharmacist who has in his possession, custody, or control dangerous drugs for any purpose other than for his own use and consumption, and includes pharmacies, hospitals, nursing homes, and laboratories, and all other persons who procure dangerous drugs for sale or other distribution by or under the supervision of a pharmacist or medical practitioner.

Admittedly, R.C. 4729.02(J) defines "sale" and "sell" broadly to include "delivery, transfer, barter, exchange, or gift, or offer therefor, and each such transaction made by any person, whether as principal proprietor, agent, or employee." However, I do not believe that a third-party payor's payment for drugs provided to its beneficiaries can be considered a "sale" of those drugs pursuant to R.C. 4729.02(J) and (Q). The beneficiaries do not pay any consideration to the third-party payor for the drugs, nor does the payor deliver or transfer the drugs to the beneficiaries, barter with the beneficiaries for the drugs, exchange anything with the beneficiaries for the drugs, or offer the drugs as a gift. At no time does the payor have the drugs in its possession, custody or control. The exchange takes place between the retailer and the beneficiaries. The payor merely reimburses its beneficiaries for the money they have expended or pays the retailer directly. In no way can the payor be said to be selling the drugs for purposes of R.C. 4729.54.

In conclusion, it is my opinion, and you are advised, that:

1. Out-of-state mail order retail pharmaceutical distributors, engaged solely in interstate commerce, are not subject to regulation by the Ohio State Board of Pharmacy under R.C. 4729.28 or R.C. 4729.51(C).

2. An out-of-state mail order retail pharmaceutical distributor, engaged solely in interstate commerce, may not be prohibited by the Ohio State Board of Pharmacy pursuant to R.C. 4729.36(A) from advertising its interstate business in Ohio, although such a distributor may be compelled to comply with the requirements of R.C. 4729.36(B).

3. Ohio third-party payors who pay out-of-state mail order retail pharmaceutical distributors for drugs provided to the payors' beneficiaries are not engaged in the sale of drugs, and need not be licensed as "terminal distributors of dangerous drugs" pursuant to R.C. 4729.54.

Respectfully,

William J. Brown

WILLIAM J. BROWN
Attorney General

BILLS PERTAINING TO OUT-OF-STATE PHARMACY IN THE STATE LEGISLATURES

PUBLIC CHAPTER NO. 244

HOUSE BILL NO. 423

By Rhinehart

Substituted for: Senate Bill No. 820

By Lewis

AN ACT relative to pharmacies and pharmacists, and to amend Tennessee Code Annotated, Title 53, Chapter 10, and Title 63, Chapter 10.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF TENNESSEE:

SECTION 1. Tennessee Code Annotated, Section 53-10-105 is amended by deleting from the first sentence the words and punctuation ", and having been dispensed by a duly licensed, registered pharmacist in this state unless" and by substituting instead the following:

> ", and having been dispensed by a pharmacy duly licensed and registered in this state, unless"

SECTION 2. Tennessee Code Annotated, Section 63-10-209 (d), is amended by deleting from the first sentence the words and punctuation:

> "The board, in addition to the powers and duties outlined in this chapter, is empowered to petition any circuit or chancery court having jurisdiction of any person within this state who is practicing pharmacy without a license"

and by substituting instead the following words and punctuation:

> "The board, in addition to the powers and duties outlined in this chapter, is empowered to petition any circuit or chancery court having jurisdiction of any person who is practicing pharmacy within this state without a license"

SECTION 3. Tennessee Code Annotated, Section 53-10-105, is amended by changing the period at the end of the second sentence to a comma, and by inserting the following language:

> and nothing in this section shall apply to a licensed physician, dentist or veterinarian nor to such drugs under the control of such physician, dentist or veterinarian in the practice of his profession, and such exemption shall include a nurse authorized pursuant to Section 63-6-204, who is rendering service under the supervision, control, and responsibility of a licensed physician, and who meets the requirements pursuant to Section 63-7-207(13).

SECTION 4. Tennessee Code Annotated, Section 63-10-201(c), is amended by deleting the words "nothing in this section" from the subsection and by substituting instead the words "nothing in this chapter".

SECTION 5. Tennessee Code Annotated, Section 53-10-105, is amended by changing the period at the end of the second sentence to a comma, and by inserting the following language:

> and nothing in this section shall apply to a licensed physician, dentist or veterinarian nor to such drugs under the control of such physician, dentist or veterinarian in the practice of his profession, and such exemption shall include a nurse authorized pursuant to Section 63-6-204, who is rendering service under the supervision, control, and responsibility of a licensed physician, and who meets the requirements pursuant to Section 63-7-207(13).

SECTION 6. Tennessee Code Annotated, Section 63-10-201(c), is amended by deleting the words "nothing in this section" from the subsection and by substituting instead the words "nothing in this chapter".

SECTION 7. This Act shall take effect on July 1, 1987, the public welfare requiring it.

PASSED: April 15, 1987

Murray

SPEAKER OF THE HOUSE OF REPRESENTATIVES

John Wilder

SPEAKER OF THE SENATE

APPROVED this 28th day of April 19 87

Ned McWherter

GOVERNOR

AMENDED IN ASSEMBLY APRIL 20, 1987

CALIFORNIA LEGISLATURE—1987–88 REGULAR SESSION

ASSEMBLY BILL No. 1953

Introduced by Assembly Member Filante

March 6, 1987

An act *to amend Section 4084.6 of, and* to add Section 4050.1 to, the Business and Professions Code, relating to pharmacy, *and making an appropriation therefor.*

LEGISLATIVE COUNSEL'S DIGEST

AB 1953, as amended, Filante. Pharmacy.

Under existing law, it is unlawful for any person to, among other things, sell or dispense any prescription of a medical practitioner unless the person is a registered pharmacist under specified provisions of the Business and Professions Code. *The law requires an out-of-state pharmacy which conducts the business of selling or distributing drugs in this state to be licensed by the Board of Pharmacy.*

This bill would require any pharmacy located outside this state which ships, mails, or delivers any controlled substances or dangerous drugs or devices into this state to register with the board, disclose specified information to the board, and meet other conditions.

The bill would also prohibit any California business entity or person who is a resident of this state from advertising the services of an out-of-state pharmacy that is not licensed by the board.

~~This bill would additionally make it unlawful for any person to dispense any prescription of a medical practitioner which is shipped, mailed, or delivered directly to a patient in this state unless the person is a registered pharmacist under specified provisions of the Business and Professions Code.~~

Existing provisions of the Business and Professions Code continuously appropriate the moneys in the Pharmacy Board Contingent Fund. Because this bill would increase the amount of moneys in the fund, it would constitute an appropriation.

A violation of those provisions of the Business and Professions Code constitutes a misdemeanor.

This bill would impose a state-mandated local program by creating or revising a crime.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: ~~no~~ *yes*. Fiscal committee: yes. State-mandated local program: yes.

The people of the State of California do enact as follows:

~~SECTION 1. Section 4050.1 is added to the Business and Professions Code, to read:~~

~~4050.1. It is unlawful for any person to dispense any prescription of a medical practitioner which is shipped, mailed, or delivered directly to a patient in this state unless the person dispensing the prescription and causing it to be shipped, mailed, or delivered is a registered pharmacist under this chapter.~~

SECTION 1. (a) The Legislature finds and declares that the practice of pharmacy is a dynamic, patient-oriented health service that applies a scientific body of knowledge to improve and promote patient health by means of appropriate drug use and drug-related therapy.

(b) The Legislature also finds that pharmacy services must be regulated by the California State Board of Pharmacy to protect the California consumer-patient and therefore enacted Section 4084.6 of the Business and Professions Code in 1968, to authorize the board to take legal action against out-of-state pharmacies that chose to

do business with California patients.

(c) The Legislature recognizes that with the proliferation of alternate methods of health care delivery, there has arisen among third-party payers and insurance companies the desire to control utilization of pharmacy services through the mandatory use of out-of-state mail order pharmacies, not registered in California.

(d) As a result, the Legislature finds and declares that to continue to protect the California consumer-patient, all out-of-state pharmacies that do business with California residents shall be registered with the board and provide pharmacy services to California patients at the same high level of protection and competence as do California pharmacies and pharmacists. To require less, would be to endanger the California resident.

SEC. 2. Section 4050.1 is added to the Business and Professions Code, to read:

4050.1. (a) Any pharmacy located outside this state which ships, mails, or delivers, in any manner, any controlled substances or dangerous drugs or devices into this state shall be considered a nonresident pharmacy, shall be registered with the board prior to doing business in this state, and shall disclose to the board all of the following:

(1) The location, names, and titles of all principal corporate officers and all pharmacists who are dispensing controlled substances or dangerous drugs or devices to residents of this state. A report containing this information shall be made on an annual basis and within 30 days after any change of office, corporate officer, or pharmacist.

(2) That it complies with all lawful directions and requests for information from the regulatory or licensing agency board of the state in which it is licensed as well as California. The nonresident pharmacy shall maintain, at all times, a valid unexpired certificate, license, permit, or registration to conduct the pharmacy in compliance with the laws of the state which it is a resident. The nonresident pharmacy shall be inspected by the regulatory or licensing agency of the state in which its

pharmacy is located as a prerequisite to California registration.

(3) That it maintains its records of controlled substances or dangerous drugs or devices dispensed to patients in this state so that the records are readily retrievable from the records of other drugs dispensed.

(b) Any pharmacy subject to this section shall, during its regular hours of operation, but not less than six days per week, and for a minimum of 40 hours a week, provide a toll-free telephone service to facilitate communication between patients in this state and a pharmacist at the pharmacy who has access to the patient's records. This toll-free number shall be disclosed on the label affixed to each container of drugs dispensed to patients in this state.

(c) It is unlawful for any California business entity or natural person, who is a resident of California, to advertise the pharmacy services of an out-of-state pharmacy that is not registered with the board.

(d) The registration fee shall be the fee specified in subdivision (a) of Section 4416.

SEC. 3. Section 4084.6 of the Business and Professions Code is amended to read:

4084.6. No out-of-state manufacturer, wholesaler, or pharmacy doing business in this state who has not obtained a certificate, license, permit, registration, or exemption from the board and who sells or distributes drugs in this state through any person or media other than a wholesaler who has obtained a certificate, license, permit, registration, or exemption pursuant to the provisions of this chapter or through a selling or distribution outlet which is licensed as a wholesaler pursuant to the provisions of this chapter, shall conduct the business of selling or distributing drugs in this state without obtaining an out-of-state drug distributor's license from the board *or registering as a nonresident pharmacy*.

Applications for an out-of-state drug distributor's license *or a nonresident pharmacy registration,* under this section shall be made on a form furnished by the board. The board may require such information as the board deems is reasonably necessary to carry out the purposes of the section.

The board may deny, revoke, or suspend such out-of-state distributor's license *or a nonresident pharmacy registration* for any violation of this chapter or for any violation of Division 21 (commencing with Section 26001) of the Health and Safety Code. The license *or nonresident pharmacy registration* shall be renewed annually on or before the first day of January of each year.

The Legislature, by enacting this section, does not intend a license *or nonresident pharmacy registration,* issued to any out-of-state manufacturer, wholesaler, or pharmacy pursuant to this section to change or affect the tax liability imposed by Chapter 3 (commencing with Section 23501) of Part 11 of Division 2 of the Revenue and Taxation Code on any out-of-state manufacturer, wholesaler, or pharmacy.

The Legislature, by enacting this section, does not intend a license *or nonresident pharmacy registration,* issued to any out-of-state manufacturer, wholesaler, or pharmacy pursuant to this section to serve as any evidence that such out-of-state manufacturer, wholesaler, or pharmacy is doing business within this state.

~~SEC. 2.~~

SEC. 4. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs which may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, changes the definition of a crime or infraction, changes the penalty for a crime or infraction, or eliminates a crime or infraction.

State of Arkansas
76th General Assembly
Regular Session, 1987
By: Representative Wimberly

A Bill

HOUSE BILL 1433

For An Act To Be Entitled

"AN ACT TO PERMIT EMPLOYEE FREEDOM OF CHOICE FOR PHARMACY SERVICES; AND FOR OTHER PURPOSES."

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF ARKANSAS:

SECTION 1. After the effective date of this Act, it shall be unlawful for any employer providing pharmacy services including prescription drugs to employees as a part of a health care program to require the employee to obtain drugs from an out-of-state mail order pharmacy as a condition of obtaining the employer's payment for such prescription drugs, or to impose upon an employee not utilizing an out-of-state mail order pharmacy designated by the employer a co-payment fee or other condition not imposed upon employees utilizing the designated out-of-state mail order pharmacy.

If the employee elects to secure pharmacy services including prescription drugs locally the employer can limit the scope of services and reimbursement therefor to an amount equal to that which would be provided under the employers out-of-state program.

SECTION 2. Any person or entity violating the provisions of this Act shall be guilty of a misdemeanor and upon conviction shall be punishable by a fine of not less than one hundred dollars ($100.00) nor more than one thousand dollars ($1,000.00) and each violation shall constitute a separate offense.

SECTION 3. All laws and parts of laws in conflict with this Act are hereby repealed.

State of Arkansas
74th General Assembly
Regular Session, 1983

A Bill

HOUSE BILL 552

By: Representative Wimberly

AS ENGROSSED 2/8/83

AS ENGROSSED 2/10/83

For An Act To Be Entitled

"AN ACT TO AMEND VARIOUS SECTIONS OF THE ARKANSAS PHARMACY LAWS TO REDEFINE THE TERM REGISTERED TO MEAN LICENSED WITH RESPECT TO PHARMACISTS; TO ALLOW FOR THE PAYMENT OF EXPENSES OF BOARD MEMBERS AND EMPLOYEES OF THE BOARD OF PHARMACY INCURRED IN THE PERFORMANCE OF THEIR DUTIES; TO REQUIRE APPLICANTS FOR LICENSURE TO HAVE GRADUATED AND RECEIVED THE FIRST PROFESSIONAL UNDERGRADUATE DEGREE FROM AN ACCREDITED PHARMACY PROGRAM APPROVED BY THE BOARD OF PHARMACY; RENAME PRACTICAL DRUGGISTS TO BE CALLED PHARMACISTS; DEFINE A SEPARATE VIOLATION FOR PENALTIES IMPOSED UNDER THE ACTS; REQUIRE OUT-OF-STATE PHARMACIES TO BE LICENSED BY THE BOARD OF PHARMACY BEFORE MAILING, SHIPPING, OR DELIVERING LEGEND DRUGS INTO ARKANSAS; ALLOW THE BOARD BY REGULATION TO DETERMINE THE REQUIRED HOLDINGS OF EACH PHARMACY LIBRARY; ALLOW THE BOARD TO GIVE COPIES OF THE BOARD OF PHARMACY LAW BOOK TO INTERNS, APPLICANTS FOR RECIPROCITY ON A ONE TIME BASIS AND TO GIVE THE LAW BOOK AS UPDATED TO EACH PHARMACY PERMIT HOLDER; ALLOW THE BOARD TO INVENTORY AND DESTROY *OUT-DATED OR UNWANTED CONTROLLED SUBSTANCES; INCLUDE ADVISING AND PROVIDING INFORMATION CONCERNING THE UTILIZATION OF DRUGS AND DEVICES AND PARTICIPATION IN DRUG UTILIZATION REVIEWS AS PART OF THE DEFINITION OF THE PRACTICE OF PHARMACY; TO RESTRICT THE USE OF THE TERMS "DOCTOR OF PHARMACY" OR "P.D" TO LICENSED PHARMACISTS; AND FOR OTHER PURPOSES."*

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF ARKANSAS:

SECTION 1. Notwithstanding any law to the contrary, whenever the term "registered", "registration" or other form of the term "register" is used with respect to the Arkansas Pharmacy Laws, the term shall be read to mean "licensed", "licensure", or other form of the term "license".

SECTION 2. Subsection 11 of Section 1 of Act 72 of 1929, the same being Arkansas Statutes *72-1001.11*, is hereby amended to read as follows:

"1 . Registered Pharmacist; when not otherwise limited, means a person holding a license under the provisions of this Act."

SECTION 3. Section 2 of Act 230 of 1957, the same being Arkansas Statutes 72-1002.2, is hereby amended to read as follows:

"Section 2. The Board of Pharmacy is hereby authorized to make reimbursement of the necessary and reasonable travel, board and lodging expenses of the staff of the Board incurred in the performance of their duties."

SECTION 4. Section 3 of Act 230 of 1957, as amended, the same being Arkansas Statutes 72-1002.3, is hereby amended to read as follows:

"Section 3. The Board of Pharmacy is hereby authorized to reimburse the members of the Board for necessary travel, meals, and lodging expenses incurred in the performance of their responsibilities as Board members, and in addition thereto, the members of the Board shall each receive forty-five dollars ($45.00) per diem while in session attending Board meetings."

SECTION 5. Section 1 of Act 57 of 1955, the same being Arkansas Statutes 72-1007.1, is hereby amended to read as follows:

"Section 1. Every applicant for examination as a pharmacist shall not be less than twenty-one (21) years of age, a citizen of the United States, of good moral character and temperate habits, and have graduated and received the first professional undergraduate degree from a pharmacy degree program which has been approved by the Board of Pharmacy. All applications for examination shall be made on a form to be supplied by the *Board of Pharmacy and shall be filed with the Board as required by Board regulations. Each application must be accompanied by an examination fee of twenty-five dollars ($25.00) plus the cost of the examination, and a certificate fee of ten dollars ($10.00).* Such examination shall be given at a time and place and in a manner set by the Board.

SECTION 6. All persons now licensed as "practical druggists" or "licensed practical druggists" under Act 57 of 1955, as amended, shall hereafter be licensed as and entitled to use the term and be called "pharmacists". *The terms "practical druggist" or "licensed practical druggist" shall hereafter be void and of no effect.*

SECTION 7. Subsection (b) of Section 1 of Act 163 of 1979, the same being Arkansas Statutes 72-1011.7a(b), is hereby amended to read as follows:

"(b) No penalty imposed by the Board may exceed five hundred dollars ($500.00) per violation, nor shall the Board impose a penalty on a licensee or a permit holder where the license of such licensee or permit holder has been revoked by the Board for such violation. Each instance when a federal or State law or Board regulation is violated shall constitute a separate violation. The power and authority of the Board to impose such penalties are not to be affected by any other proceeding, civil or criminal, concerning the same violation, nor shall the imposition of such penalty preclude the Board from imposing other sanctions short of revocation."

SECTION 8. Hereafter, any pharmacy operating outside the State which ships, mails, or delivers in any manner a dispensed legend drug into Arkansas shall hold a pharmacy license issued by the Arkansas State Board of Pharmacy and that part of the pharmacy operation dispensing the prescription for an Arkansas resident shall abide by Arkansas law and regulations of the Board.

SECTION 9. Section 11 of Act 72 of 1929, the same being Arkansas Statutes 72-1022, is hereby amended to read as follows:

"Section 11. There shall be kept in every pharmacy a library consisting of books and periodicals as required by Board regulations."

SECTION 10. Section 1 of Act 480 of 1965, as amended, the same being Arkansas Statutes 72-1042, is hereby amended by adding the following new subsection (o):

"(o) The fee for the Board of Pharmacy law book shall be five dollars ($5.00) except to interns on initial licensure, and applicants for reciprocity, on a one time basis. A copy of each edition as revised shall be provided free to each pharmacy permit holder."

Mississippi
Executive Department
Jackson

March 25, 1986

TO THE MISSISSIPPI STATE SENATE:

I return herewith Senate Bill No. 2546: "AN ACT TO AMEND SECTION 73-21-73, MISSISSIPPI CODE OF 1972, TO DEFINE THE TERM "EXTRATERRITORIAL PHARMACY" TO MEAN A PHARMACY LOCATED OUTSIDE OF MISSISSIPPI THAT DISPENSES PRESCRIPTION DRUGS TO PERSONS IN MISSISSIPPI; TO CREATE NEW SECTIONS TO BE CODIFIED AS SECTION 73-21-106, 73-21-108 AND 73-21-110, MISSISSIPPI CODE OF 1972, TO PROVIDE FOR THE REGULATION OF EXTRATERRITORIAL PHARMACIES BY THE STATE BOARD OF PHARMACY; TO PRESCRIBE CERTAIN REQUIREMENTS THAT EXTRATERRITORIAL PHARMACIES MUST COMPLY WITH IN ORDER TO DO BUSINESS IN THIS STATE; TO PROVIDE THAT THE STATE BOARD OF PHARMACY MAY ASSESS THE COST OF CONDUCTING INSPECTIONS OF EXTRATERRITORIAL PHARMACIES TO SUCH PHARMACIES; TO ALLOW THE STATE BOARD OF PHARMACY TO CONTRACT WITH AGENCIES THAT REGULATE PHARMACISTS IN OTHER STATES TO CARRY OUT SUCH INSPECTIONS; TO ALLOW THE STATE BOARD OF PHARMACY TO ESTABLISH BY RULE AND REGULATION THE CRITERIA FOR THE PACKAGING, SHIPPING AND MAILING OF PRESCRIPTION DRUGS BY A RETAIL INSTITUTIONAL OR EXTRATERRITORIAL PHARMACY; TO AMEND SECTIONS 73-21-101 AND 73-21-105, MISSISSIPPI CODE OF 1972, IN CONFORMITY THERETO; AND FOR RELATED PURPOSES.", without my approval, and in so doing respectfully assign the following reasons for veto:

Senate Bill No. 2546 would require pharmacies operating outside the State of Mississippi which mail dispensed prescription drugs into the state to: (1) be licensed in the state in which it is located; (2) comply with all Mississippi statutes and regulations; (3) employ at least one (1) pharmacist licensed by Mississippi; (4) maintain records in a readily retrievable manner; (5) maintain a set of Mississippi statutes and regulations; (6) provide 24-hour toll free WATS for patients to call pharmacist licensed by Mississippi with access to patient's prescription records.

There is no question that the State has broad police powers with respect to protecting the health, safety and welfare of its citizens. However, state regulatory measures are not presumptively constitutional.

The constitutionality of a state's attempt to license or otherwise regulate out-of-state pharmacies which mail prescription drugs into the state has been considered by various authorities with differing results.

The United States Supreme Court has established the following criteria for determining the validity of state statutes affecting interstate commerce under the Commerce Clause of the United States Constitution (Article I, Section 8, Clause 3) which prohibits the imposition by a state of unreasonable burdens upon interstate commerce: Where the statute regulates evenhandedly to effectuate a legitimate local public interest, and its effects on interstate commerce are only incidental, it will be upheld unless the burden imposed on such commerce is clearly excessive in relation to the putative local benefits. If a legitimate local purpose is found, then the question becomes one of degree. The extent of the burden that will be tolerated will, of course, depend on the nature of the local interest involved, and on whethe it could be promoted as well with a lesser impact on interstate activities. Pike v. Bruce Church, Inc., 397 U.S. 137, 142 (1970).

The Court has made clear that where means exist which are less burdensome to the flow of interstate commerce and which are adequate to serve the would-be regulatory state's interest, the challenged regulatory scheme cannot stand.

In this case, if that out-of-state pharmacy dispenses drugs through the mail to customers in a number of states, it would seem that having to meet the licensing requirement of each particular state would impose a substantial burden upon the pharmacy's ability to engage in interstate commerce. In such an instance, the pharmacy involved would be subject to multiple licensing procedures, including duplicative registration, records requirements and labeling requirements.

Most importantly, Senate Bill No. 2546, requires an out-of-state pharmacy to provide a 24-hour toll free WATS line to facilitate communications between the patient and a pharmacist licensed in this state who shall have access to the patient's prescription records as maintained by that pharmacy. This requirement demands that the out-of-state pharmacy employ three (3) Mississippi licensed pharmacists around the clock in order to comply therewith. Since no Mississippi pharmacy must remain open 24 hours, the imposition of that requirement on an out-of-state pharmacy is clearly excessive in relation to the putative local benefits. The state's regulatory interest under this bill is simply not great enough to justify the burden which this bill would place upon interstate commerce. Therefore, Senate Bill No. 2546 is of suspect constitutional validity under the criteria established in Pike. Being of that opinion, I cannot approve this bill.

Respectfully submitted,

WILLIAM A. ALLAIN
GOVERNOR

Community Pharmacy (Class A)

★22 TAC §291.39

The Texas State Board of Pharmacy adopts new §291.39, with changes to the proposed text published in the March 24, 1987 issue of the *Texas Register* (12 TexReg 985). Nonsubstantive changes appear in subsection (e)(2)(D) and (E), regarding records, subsection (f)(3)(A)(*ii*), regarding substitution on prescriptions, subsection (i)(1) regarding copies of prescriptions dispensed to Texas residents, and new subsection (j) regarding disciplinary action. These changes were made as a result of comments received during the public hearing and public comments period.

The new section provides adequate safeguards to the citizens of Texas when their drugs are dispensed by facilities not located in the state of Texas.

The new section provides standards in the conduct, practice, activities, and operation of a pharmacy located in a state in the United States other than Texas, that dispense prescriptions to Texas residents using the United States Postal Service or other common carrier.

Comments received in support of the new section endorsed the regulations requiring that pharmacists located in states other than Texas dispensing prescriptions to Texas residents through the United States Postal Service or other common carriers, be registered with the Board of Pharmacy. Additionally, these comments endorsed the requirement that the pharmacist-in-charge of such a pharmacy be licensed by the State of Texas and that compliance with appropriate state laws be required. Comments received against the proposed rule included the following.

Concerning Subsection (d), comments stated that out-of-state pharmacies did not want to obtain a pharmacy license because the public benefits of providing standards for out-of-state pharmacies can be provided without the imposition of provisions that violate the United States Constitution or deprive Texans of the option of purchasing their maintenance drugs from mail order pharmacies. Regulations are considered to be in violation of the Commerce Clause of the United States Constitution on the grounds that it imposes an undue burden on interstate commerce that is not balanced by a reasonable means of protecting commensurate local interests.

An alternative solution suggested a disclosure statute which does not require a formal and revocable license by an out-of-state pharmacy and does not subject the pharmacy to Texas rules and regulations in addition to those of its home locality. A second section was also recommended to enable the Texas Board of Pharmacy to facilitate and enhance the enforcement efforts of other boards with jurisdiction over mail service pharmacies which serve Texas residents. The board disagreed. In addition, the board included subsection (j) to address the enforcement provisions of the Texas Pharmacy Act.

Concerning subsection (c), comments received stated that out-of-state pharmacies would be unable to comply with this section because they did not employ a pharmacist licensed in Texas. Further, it would be too burdensome to have a staff pharmacist become licensed in Texas, especially if all states required an out-of-state pharmacy to obtain a license and employ a pharmacist licensed in their state. This situation would require the out-of-state pharmacy to have 50 pharmacy licenses, and a pharmacist with licenses in 50 states. The board disagrees.

Subsection (e)(2)(D), requires an out-of-state pharmacy to dispense a Schedule II controlled substance after the second day following the date of issuance, which is consistent with the Texas Controlled Substances Act. Comments received stated that a two-day time period was unreasonable since patients had to rely on the United States Postal Service to mail their prescriptions to an out-of-state pharmacy. The board agreed and changes are made.

Subsection (e)(2)(E) required an out-of-state pharmacy to mail Copy I of the Texas triplicate form to the Texas Department of Public Safety. Comments received stated that an out-of-state pharmacy was required to retain original records on file in the state in which the pharmacy was located. The board agreed and changes are made.

Subsection (f)(3)(*ii*) addressed substitution on prescriptions not issued in Texas. Comments stated this requirement may cause out-of-state pharmacies to violate the substitution regulations in the state in which the pharmacy was located. The board agreed and changes are made.

Concerning subsection (i)(1), the comments received stated that an out-of-state pharmacy was required to retain original records on file in the state in which the pharmacy was located. The board agreed and changes are made.

The Attorney General of Texas rendered Opinion JM-555, based upon the Texas Pharmacy Act, which states in part: "Out-of-state mail-order pharmacists or pharmacies which fill prescriptions for Texas residents clearly deliver, dispense, or distribute those prescriptions in Texas. Consequently, the legislature granted authority in Sections 17 and 19 of Article 4542a-1 to regulate mail-order sales or transfers of prescription drugs from out-of-state pharmacists and pharmacies to persons within Texas with regard to the aspects of such practice that may directly affect users residing in Texas. The Texas State Board of Pharmacy may regulate out-of-state mail-order pharmacists only to the extent that they actually engage in the practice of pharmacy or dispense, deliver, or distribute prescription drugs within the state of Texas. Such regulation is not per se unconstitutional under the Commerce Clause of the United States Constitution."

The board believes these rules are necessary to provide adequate safeguards to the citizens of Texas when their drugs are dispensed by facilities not located in the state. Unless these pharmacies are licensed by TSBP, the board has no mechanism to regulate their practices in the public interest. In addition, the rules which have been proposed by the TSBP serve a legitimate public interest and do not appear to impose an unreasonable burden on interstate commerce. The proposed section represents the minimum standards needed to protect the health, safety, and welfare of the citizens of Texas who receive services from pharmacies operating outside the State of Texas.

The Texas Pharmaceutical Association, and the Texas Department of Public Safety commented for the new section. The American Association of Retired Persons,

Preferred Prescription Service, Texas Retired Persons Pharmacy, Medco Containment Services, Inc., and Baxter Travenol Labs, commented against the new section.

The new section is adopted under Texas Civil Statutes, Article 4542a-1, §17 and §19, which provide the Texas State Board of Pharmacy with the authority to regulate mail-order sales or transfers of prescription drugs from out-of-state pharmacists or pharmacies to persons within Texas with regard to the aspects of such practice that may directly affect users residing in Texas.

§291.39. Pharmacies Located in a State other than Texas.

(a) Definitions. The following words and terms, when used in this section, shall have the following meanings, unless the context clearly indicates otherwise.

(1) Act—The Texas Pharmacy Act, Texas Civil Statutes, Article 4542a-1.

(2) Board—The Texas State Board of Pharmacy.

(3) Controlled substance—A drug, immediate precursur, or other substance included in Schedule I, II, III, IV, or V of the Federal Comprehensive Drug Abuse Prevention and Control Act of 1970, as amended (Public Law 91-513).

(4) Dangerous drug—Any drug or device that is not a controlled substance and that is unsafe for self-medication or any drug or device that bears or is required to bear the legend:

(A) "Caution: federal law prohibits dispensing without prescription;" or

(B) "Caution: federal law restricts this drug to use by or on the order of a licensed veterinarian."

(5) Dispense—Preparing, packaging, compounding, or labeling for delivery a prescription drug or device in the course of professional practice to an ultimate user or his agent by or pursuant to the lawful order of a practitioner.

(6) Distribute—The delivery of a prescription drug or device other than by administering or dispensing.

(7) Generically equivalent drug—A drug that is pharmaceutically equivalent and therapeutically equivalent to the drug prescribed.

(8) Pharmaceuticlly equivalent drugs—Drug products which have identical amounts of the same active chemical ingredients in the same dosage form and which meet the identical compendial or other applicable standards of strength, quality, and purity according to the United States Pharmacopeia or other nationally recognized compendium.

(9) Pharmacist-in-charge—The pharmacist designated on a pharmacy license as the pharmacist who has the authority or responsibility for a pharmacy's compliance with laws and rules pertaining to the practice of pharmacy.

(10) Practitioner

(A) A physician, dentist, podiatrist, veterinarian, or other person licensed or registered to distribute or dispense a prescription drug or device in the course of professional practice in this state;

(B) A person licensed by another state in a health field in which, under Texas law, licensees in this state may legally prescribe dangerous drugs; or

(C) A person practicing in another state and licensed by another state as a physician, dentist, veterinarian, or podiatrist, having a current Federal Drug Enforcement Administration registration number, and who may legally prescribe Schedule II, III, IV, or V controlled substances in such other state. Practitioner does not include a person licensed under this Act.

(11) Prescription drug order—A written order from a practitioner or a verbal order from a practitioner or his authorized agent to a pharmacist for a drug or device to be dispensed.

(12) Therapeutically equivalent drugs—Pharmaceutically equivalent drug products which, when administered in the same amounts, will provide the same therapeutic effect, identical in duration and intensity.

(b) Purpose. The purpose of this section is to provide standards in the conduct, practice, activities, and operations of a pharmacy located in a state in the United States other than Texas that dispense prescriptions to Texas residents using the United States Postal Service or other common carrier.

(c) Personnel.

(1) All pharmacists shall have a current license in good standing to practice pharmacy in the state where the pharmacy is located.

(2) At least one pharmacist shall be licensed to practice pharmacy by the Texas State Board of Pharmacy, which such pharmacist shall be designated as the pharmacist-in-charge on the pharmacy license issued by the Texas State Board of Pharmacy.

(3) The pharmacist-in-charge shall ensure that the pharmacy is in compliance with laws and rules governing the practice of pharmacy in the state where the pharmacy is located, and federal laws or rules governing the practice of pharmacy and the rules set out in this section.

(d) Licensing requirements.

(1) A pharmacy located in a state in the United States other than Texas that dispenses prescriptions to Texas residents using the United States Postal Service or other common carrier shall register annually with the board on an application provided by the board.

(2) The pharmacist-in-charge of the pharmacy and the owner/managing executive officer of the pharmacy shall sign the application and shall agree to comply with the board rules set out in this section.

(3) The application shall be notorized and state whether the pharmacy is a sole ownership and give the name of the owner, or if a partnership, name all the managing partners, or if a corporation, name all the managing officers.

(4) The pharmacy shall have a current pharmacy license in good standing issued by the state in which the pharmacy is located.

(5) When a pharmacy changes ownership, a new and separate license application must be filed with the board and the previously issued license returned to the board's office with the application for a new license.

(6) When a pharmacy changes name and/or location, an application for an amended license must be filed with the board and the previously issued license returned to the board's office with the applicaton for an amended license.

(7) The fees as set out in §291.6 of this title (relating to Pharmacy License Fees) shall be charged for the issuance of a new license, the renewal of a pharmacy license, or the issuance of an amended license.

(8) A separate license is required for each principle place of business and only one pharmacy license may be issued to a specific location.

(9) A pharmacy shall notify the board in writing within 10 days of a change of the pharmacist-in-charge.

(10) A pharmacy shall notify the board in writing within 10 days of permanent closing.

(e) Records.

(1) General. Records of controlled substances and noncontrolled prescription drugs shall be maintained in accordance with the laws and rules of the state where the pharmacy is located.

(2) Triplicate Prescriptions.

(A) A Schedule II controlled substance prescription issued in Texas may not be dispensed without a prescription of a practitioner written on a triplicate prescription form provided by the Texas Department of Public Safety.

(B) Upon receipt of Copy 1 and Copy 2 of a properly completed Texas triplicate prescription for a Schedule II controlled substance, each dispensing pharmacist shall utilize the "Pharmacy Use Only" section and record the following:

(i) pharmacy name, address, area code/telephone number, and Drug Enforcement Administration number. This information may be printed, typed, or rubber stamped, or the pharmacist may use a label that is securely affixed in this area;

(ii) the dispensing pharmacist's signature, entered in a space located directly below the pharmacy information; and

(iii) the date filled and the pharmacy prescription number, entered in the spaces provided.

(C) The dispensing pharmacist shall ensure that the drug prescribed and/or its substitute is legible on Copy 1 and Copy 2 of the triplicate prescription.

(D) No Schedule II prescription

may be dispensed after the end of the seventh day following the date of issuance.

(E) Within 30 days from the date a pharmacist dispenses a triplicate prescription, the pharmacy is required to mail a photocopy of Copy 1 of the form to the Texas Department of Public Safety, Triplicate Prescription Section, P.O. Box 4087, Austin, Texas 78773.

(f) Drug product selection.

(1) Pharmacist's responsibility. The determination of the drug product to be substituted as authorized by the Act, §40, is the professional responsibility of the pharmacist, and the pharmacist may not dispense any product that does not meet the requirements of the Act §40.

(2) Notification. A pharmacist who selects a generically equivalent drug product as authorized by the Act, §40, shall inform the patient or the patient's agent prior to delivery of a generically equivalent drug product through one of the following methods:

(A) personally or telephonically, or through his agent or employee, that a less expensive generically equivalent drug product has been substituted for the brand prescribed and that the patient or his agent has the right to refuse such substitution; or

(B) written notice provided to the patient or his agent, in both English and Spanish, which reads: "Texas law allows a less expensive generically equivalent drug to be substituted for certain brand name drugs unless your physician directs otherwise. You have a right to refuse such substitution. Consult your physician or pharmacist concerning the availability of a safe, less expensive drug for your use;" "Las leyes de Texas permiten que se sustituya una medicina genericamente equivalente y menos cara por ciertas medicinas de marca reconocida a menos que su medico instuya de otra manera. Ud. Tiene el derecho de rehusar dicha sustitucion. Consulte a su medico o farmaceutico con referencia a la disponibilidad de una medicina segura y menos cara para su uso."

(3) Records.

(A) Written prescription drug orders.

(i) A pharmacist may not dispense a prescription issued in Texas unless it is ordered on a form containing two signature lines of equal prominence, side by side, at the bottom of the form. Under either signature line shall be printed clearly the words "product selection permitted," and under the other signature line shall be printed clearly the words "dispense as written." If the practitioner's signature does not clearly indicate that the prescription must be dispensed as written, generally equivalent drug selection is permitted.

(ii) Substitution on prescriptions not issued in Texas shall be in accordance with the laws and rules of the state where the pharmacy is located.

(B) Oral prescription drug orders.

(i) If a prescription is transmitted to a pharmacist orally, the pharmacist shall note any dispensing instructions by the practitioner or practitioner's agent on the file copy of the prescription.

(ii) Such file copy may follow the two-line format indicated in subparagraph (A)(*i*) of this paragraph, or any other format that clearly indicates the dispensing instructions.

(iii) Refills authorized on such prescription shall follow the original dispensing instructions, unless otherwise indicated by the practitioner or practitioner's agent.

(iv) If the practitioner or practitioner's agent does not indicate that the prescription drug must be dispensed as ordered, generically equivalent drug selection is permitted.

(C) Product Selection. If a generically equivalent drug is dispensed on oral or written prescriptions, the pharmacist shall note on the face of the prescription the name, strength, and manufacturer or distributor of the drug product actually dispensed. This information shall also be indicated:

(i) on the prescription, when it is refilled with a generically equivalent drug from a different manufacturer or distributor than was previously dispensed; and

(ii) on the patient medication records, if such document is utilized for providing and recording refill information.

(g) Labeling requirements. The label affixed on the dispensing container of any prescription dispensed by a pharmacy pursuant to a prescription drug order shall bear:

(1) unique identification number of the prescription;

(2) the name and address of the pharmacy;

(3) the name of the patient, or if such drug was prescribed for an animal, the species of the animal and the name of its owner;

(4) the name of the prescribing practitioner;

(5) the date of prescription is dispensed;

(6) the instructions for use;

(7) unless otherwise directed by the prescribing practitioner, in addition to the information listed in this subsection, either the brand name and strength, or if no brand name, then the generic name of the drug dispensed, the strength of the drug, and the name of the manufacturer or distributor of such generic drug, on the label. The name of the manufacturer or distributor may be reduced to an abbreviation or initials, provided the abbreviation or initials are sufficient to identify the manufacturer or distributor. For combination drug products having no brand name, the principal active ingredients shall be indicated on the label; and

(8) if a drug product is dispensed other than the one prescribed, the statement, "Substituted for brand prescribed," or an auxiliary label bearing such statement, affixed to the dispensing container. The brand name of the prescribed drug shall not appear on the prescription label unless it is the drug product actually dispensed.

(h) Library. A reference library shall be maintained which includes current copies of the following:

(1) Texas Pharmacy Act and Rules;

(2) Texas Dangerous Drug Act;

(3) Texas Controlled Substances Act and Rules; and

(4) Federal Controlled Substances Act and Regulations (or official publication describing the requirements of the Federal Controlled Substances Act and Regulations).

(i) Records to be provided to the Texas State Board of Pharmacy.

(1) At the request of the Texas State Board of Pharmacy, a pharmacy shall provide the Texas State Board of Pharmacy, certified copies of prescriptions dispensed to Texas residents.

(2) A pharmacy shall provide the board copies of any inspection reports resulting from an inspection conducted by the State Board of Pharmacy of the state where such pharmacy is located.

(j) Disciplinary action. The board may, in its discretion, refuse to issue or renew a license or may fine, reprimand, revoke, restrict, cancel, or suspend any license granted by the board, and may probate any license suspension, if the board finds that the applicant or licensee has violated any provision of the Act, §26.

This agency hereby certifies that the rule as adopted has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Issued in Austin, Texas, on July 31, 1987.

TRD-8706365

Fred S. Brinkley, Jr.
Executive
Director/Secretary
Texas State Board of
Pharmacy

Effective date: August 24, 1987
Proposal publication date: March 24, 1987
For further information, please call
(512) 832-0661.

REPORTS AND PAPERS ON MAIL-ORDER PHARMACY

spectrum
Pharmaceuticals
Products and Technologies

Rapid Growth for Mail-Order Drug Dispensing

Marcia D. Codling
Health Industries Management Section

The rapid expansion of the mail-order drug industry over the next five years will reshape the retail drug business. This growth will contribute to changes in the drug distribution network, creating risks for wholesalers and drugstores and mainly opportunities for manufacturers.

Summary

Mail-order sales of prescription pharmaceuticals grew 50%/year from less than $100 million in 1981 to $750 million in 1986. We estimate that mail-order sales will increase 30%/year through 1991, reaching $2.8 billion, or 10% of the total U.S. market.

Price and convenience are the major forces behind the growth of mail-order dispensing. Mail-order firms can save customers 5-40% on their drug costs through volume purchasing, generic substitution, automated dispensing, and multimonth supplies. The convenience of at-home shopping and large supplies is especially valued by older Americans.

The mail-order industry has more than two dozen participants, which we group into four categories: nonprofit organizations, for-profit health care companies, chain drugstores, and companies from allied businesses.

The growth of mail-order sales will contribute to broader changes in drug distribution. The power of buying groups and purchasing agents will grow. Manufacturers will sell directly to large mail-order dispensers, buying groups, and repackagers that serve dispensing physicians. By 1995 alternative dispensing will be a major challenge to traditional distributors, and drugstores will account for only 60% of the U.S. dispensing market, down from 80% in 1985.

Market Size and Growth

Sales of prescription drugs through the mail in the United States have expanded rapidly in recent years. From less than $100 million in 1981, U.S. mail-order drug sales grew 50%/year to an estimated $750 million in 1986. Although mail-order dispensing now accounts for less than 4% of the $21-billion U.S. prescription pharmaceuticals market, we believe it will grow 30%/year over the next five years, commanding a 10% share of the $28.5-billion market by 1991. Drugs provided through mail order are almost exclusively for chronic therapy, a category that accounts for about 70% of all prescription pharmaceutical sales in the United States.

Forces Fueling Growth

The most important forces behind the growth of mail-order dispensing are price and convenience.

Price. Mail-order firms save customers, whether individual consumers or corporate benefit plans, 5-40% on their drug costs. These savings are possible because mail-order firms can:

- Make large purchases;
- Aggressively substitute generic drugs;
- Dispense 90-day or even 180-day supplies to patients (as opposed to 30-day or smaller supplies in most drugstores); and
- Centralize dispensing to achieve economies of scale.

Table 1 shows, using a hypothetical but realistic example, how a mail-order service can lower the cost of drugs to both a corporate benefit program and the employees it serves through lower fees and ingredient costs.

Convenience. Mail-order also offers convenience in the form of at-home shopping and large supplies; prescriptions may be filled only three or four times a

Table 1

Cost Comparison of Drug Benefit Programs (dollars per 90-day supply)

	Major Medical	Card Program	Mail-Order
Ingredient Cost	15.00	15.00	13.50
Dispensing Fee	9.75	9.00	1.45
Claim Processing Fee	5.00	1.95	—
Total	29.75	25.95	14.95
Copayment	(9.00)	(9.00)	(3.00)
Net Cost to Employer	20.75	16.95	11.95

Note: Major medical and card program costs based on three 30-day prescriptions; mail-order costs based on one 90-day prescription.

Source: Arthur D. Little, Inc., estimates.

year rather than each month. Convenience is an especially great concern for the growing number of older Americans, who make up about 12% of the U.S. population but consume about 30% of its prescribed pharmaceuticals. Many older persons have limited mobility and take one or more maintenance drugs.

Participants

The industry already has more than two dozen participants, which we can group into four main categories (Table 2). The largest group (in terms of mail-order volume) consists of two nonprofit organizations: the Veterans Administration (which has provided veterans with free drugs through the mail for decades and is really outside the industry) and the American Association of Retired Persons (AARP). Between 10% and 15% of the AARP's 24 million members use its mail-order drug service, which has been administered by Retired Persons Services since the early 1980s.

The for-profit health care companies in the mail-order drug business include Medco Containment Services (the largest in the group), Health Care Services, Baxter Travenol Laboratories, MediRx America, American Prescription Plan, and roughly half a dozen others. A third major group, chain drugstores, recently entered this promising growth area, led by Walgreen and Thrift Drug's Express Pharmacy Services (J.C. Penney). Because the large chains are familiar with drug retailing and consumer marketing, we expect them to become significant mail-order dispensers by the early 1990s. For chains that already provide drugs as part of third-party plans, mail-order is simply a new delivery channel.

Table 2

Selected Participants in Mail-Order Dispensing by Category, 1986

Nonprofit Organizations
Retired Persons Services (American Association of Retired Persons)
Veterans Administration

Health Care Companies
American Medical International
America's Pharmacy (Caremark)[1]
American Prescription Plan (Medivix)
Health Care Services
Medco Containment Services (Porex Technologies)
MediRx America
Preferred Prescription Service (Baxter Travenol Laboratories)

Drugstore Chains
Action Mail Order Drug (LaVerdiere's)
Express Pharmacy Services (Thrift Drug/J.C. Penney)
Walgreen

Others
ArcVentures (Rush Presbyterian-St. Luke's Medical Center of Chicago)
Blue Cross/Blue Shield
Capital Area Community Health Plan
Mature Outlook (Sears, Roebuck)

1. On April 2, 1987, Caremark agreed to sell America's Pharmacy to Newport Pharmaceuticals International for $12 million.

Source: Arthur D. Little, Inc.

The last group of participants consists of companies from several allied businesses. They include Blue Cross/Blue Shield, which offers mail-order dispensing to federal employees; ArcVentures, a for-profit subsidiary of Rush Presbyterian-St. Luke's Medical Center of Chicago; and Capital Area Community Health Plan, a small New York health maintenance organization. Sears, Roebuck, which has sold home health care equipment through the mail for over 50 years, now offers mail-order drugs through its Mature

Outlook program for older persons; Walgreen holds the dispensing contract. Size should give several of these large entrants an advantage, especially when they sell to corporate clients who choose to add mail-order drug dispensing to their employee health plans.

The six largest industry participants accounted for about two-thirds of prescriptions filled by mail-order in 1986 (Table 3). Their major customers have been benefit programs offered by large employers, state governments, and unions.

Market Impact

The growth of mail-order drug sales that we foresee will coincide with and contribute to broader changes in the drug distribution network. Figure 1 shows our view of the structure of that network in the United States in 1975, 1985, and 1995. In the 1975 network, most drugs (over 80% in recent years) went through wholesalers to hospitals and drugstores. Manufacturers promoted their products mainly to the physician.

By 1985 important alternative channels had emerged within the drug distribution network. Wholesalers remained the largest buyers of drugs from the manufacturer, but buying groups and purchasing agents representing hospitals, health maintenance organizations, or large group practices were important decision makers as well. Manufacturers promoted and in some cases sold directly to these new participants in the network. Also, mail-order services and physicians had become significant dispensers of drugs to consumers, while alternative sites served a greater share of the population.

We expect that by 1995 alternative dispensing will be a major challenge to traditional distributors. Manufacturers will sell directly to large mail-order dispensers, buying groups, and repackagers that serve dispensing physicians. We estimate that in 1995 drugstores will account for only 60% of the U.S. drug-dispensing market, down from 85% in 1975 and 80% in 1985.

Table 3

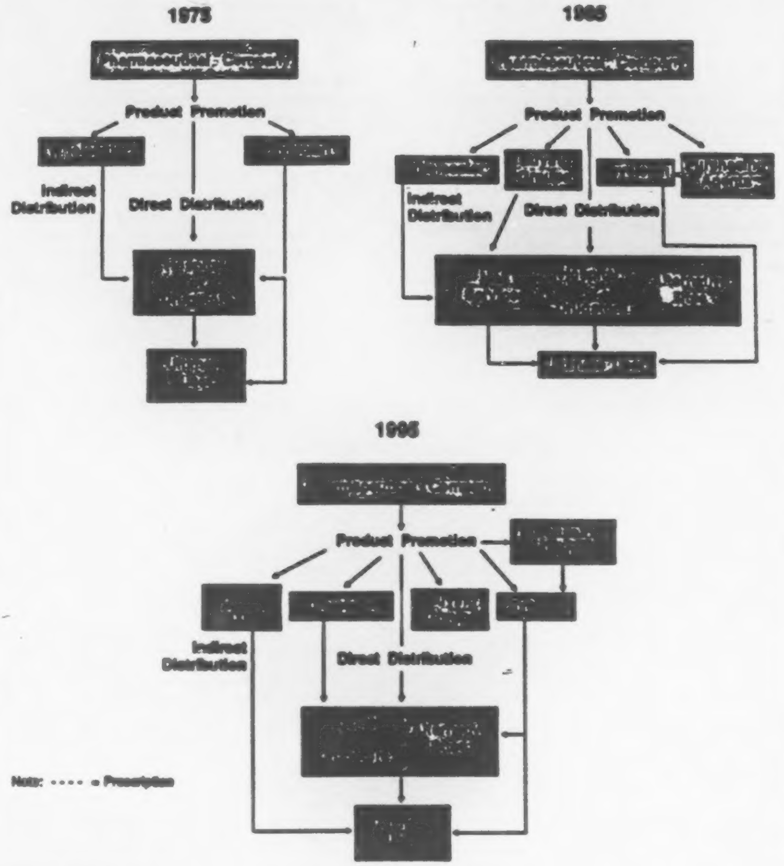
Major Participants in Mail-Order Dispensing, 1986

Participants	Number of Prescriptions (MM)	Major Customers
Veterans Administration	20	U.S. veterans
Retired Persons Services (American Association of Retired Persons)	8	AARP members
Medco Containment Services (Porex Technologies)	6	Alcoa, General Motors, Occidental Petroleum, United Technologies, International Ladies Garment Workers Union, Public Employees Retirement System of Ohio, State Teachers Retirement System of Ohio
Health Care Services	1.5	Ford, Goodyear, Pennsylvania state employees
Express Pharmacy Services (Thrift Drug/J.C. Penney)	1	Chevron, General Motors, Pitney Bowes, Rockwell
Preferred Prescription Service (Baxter Travenol Laboratories)	1	Ameritech, Amoco, Bell Atlantic, Southland, Texaco, Texas Instrument

Source: Arthur D. Little, Inc., estimates.

Figure 1

The U.S. Drug Distribution Network


1975
Product Promotion
Indirect Distribution
Direct Distribution
1985
Product Promotion
Indirect Distribution
Direct Distribution
1995
Product Promotion
Indirect Distribution
Direct Distribution

Note: - - - - = Prescription

Source: Arthur D. Little, Inc.

Manufacturers

The rapid growth of mailForder drug dispensing will not have a profound effect on the large pharmaceutical companies. Nevertheless, the trend may increase the impact of generic substitution, and many companies will concede some margin in order to negotiate volume purchases from the largest mail-order services. A few manufacturers may enter the business as part of overall strategies aimed at taking advantage of likely changes in the drug distribution network.

Wholesalers

Despite their sophisticated distribution systems, the major wholesalers are unlikely to join the mail-order business themselves in the next five years. To do so would harm their relations with the retail pharmacies that account for much of their sales. Instead, the major distributors will supply the mail-order firms, treating them as an alternative delivery channel. Those firms that supply mainly independent community pharmacies will lose business as their customers do. Eventually, however, some wholesalers will integrate forward by launching or acquiring mail-order drug dispensers.

Drugstores

Mail-order dispensing clearly threatens the community drugstore's prescription pharmaceutical sales. Moreover, since the pharmacy often serves as a draw while high-margin over-the-counter drugs and general merchandise provide most of the profits, losing prescription sales has a multiplied effect.

So far, community pharmacies have responded to this competitive threat by maintaining that mail-order dispensing endangers patients and reduces the quality of care. Pharmacist organizations have sought to publicize the negative aspects of mail-order dispensing. Table 4 shows community pharmacists' major criticisms of the mail-order industry and the mail-order industry's responses.

Pharmacist organizations are lobbying state pharmacy boards and legislatures to ban or control mail-order firms. Some states do not permit mail-order firms within their borders, although the firms can still

Table 4

Pros and Cons of Mail-Order Dispensing

Criticism	Defense
Eliminates interaction with pharmacist, who explains use of drug, checks for side effects, and ensures customer is not taking medication that might react with prescription.	Real patient counseling in drugstores is rare; FDA study found only 19% of consumers cited pharmacists as main source of drug information.
Faceless dispensing leads to more mistakes.	No studies compare error rates of mail-order and community pharmacies; Medco, the largest for-profit mail-order pharmacy, claims an error rate of under 1% with highly automated dispensing.
Drugs can be stolen, tampered with, or damaged by extreme temperatures during shipping.	Packages are insulated and unmarked; temperature damage is a problem faced and largely solved by the entire pharmaceutical industry.
Cost savings may be illusory; a 1986 study concluded that although unit costs were lower with mail-order, overall costs were higher owing to waste associated with multi-month supplies.	Study dealt with small sample and specific contract and is therefore of limited value; some firms are reining in multi-month supply practice.

Source: Arthur D. Little, Inc.

send drugs into these states. Attorneys general in several states have also ruled that out-of-state mail-order firms must be licensed in the state if they ship products to state residents. So far, no state board of pharmacy has filed suit to test such a ruling. The Federal Trade Commission is monitoring the situation and is likely to oppose such state regulation on the grounds that it illegally restrains interstate commerce. A test case may be brought in Arkansas in 1987. Even if such laws are upheld, enforcing them will probably prove impractical.

The mail-order drug industry is responding to legitimate demands for cost control and convenience. Its success signals that the bases of competition in retail pharmacy are changing. Walgreen, Thrift Drug/J.C. Penney, and LaVerdiere's have already entered the mail-order business, as have a handful of independent drugstores. We expect that more community pharmacies will do the same. Entering the mail-order drug business may be an especially workable approach for networks of small chains and independent drugstores. Both chain and independent drugstores are likely to seek mail-order drug dispensing contracts with managed-care systems such as health maintenance organizations and preferred provider organizations.

Community pharmacists can match many of the features mail-order companies offer while differentiating themselves by providing a measure of personal service. The California Pharmacists Association, for example, has begun to sell pharmacy service contracts to major employers. These contracts feature aggressive substitution of generic for brand-name drugs and allow larger supplies of certain medications to be dispensed. Unlike mail-order arrangements, however, they feature personal service to customers.

About the Author

Marcia D. Codling is a member of the Health Industries Management Section of Arthur D. Little, Inc. Her consulting assignments focus on business strategies for over-the-counter drugs, generic drugs, and nutritional supplements, as well as for prescription drug markets in developing countries. Ms. Codling holds degrees in pharmacy, hospital administration, and business management.

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MAIL ORDER PHARMACY
IN THE UNITED STATES

A special report prepared for the
Louisiana Board of Pharmacy

by Ed Reed

July, 1986

505 ROUMAIN BUILDING, 343 RIVERSIDE MALL, BATON ROUGE, LA. 70801 504/343-0696

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INTRODUCTION AND ACKNOWLEDGEMENTS

This report was commissioned by the Louisiana Board of Pharmacy in connection with its efforts to implement legislation passed during the 1985 regular session of the Louisiana legislation allowing the board to regulate mail service pharmacy.

There were no conditions attached to the contract. I was given no special instructions and I was given no preconceived conclusions to guide me. I was simply told that the board wanted to administer the law in the most equitable and most effective manner possible, and wanted the historical background and present status of mail order pharmacy in America. The board felt that it could benefit from others' experience.

I have reached certain conclusions and these are contained in the last section of this report. The reader should understand that I am retained by the community pharmacists of Louisiana and was instrumental in passing the legislation that allowed the board to regulate out-of-state pharmacy. I cite this fact and leave it to those who study this report to determine whether it has colored, to any degree, the contents.

I was fortunate to have the unstinting cooperation of many people throughout the country in preparing this report. My office talked with the staff of 48 of the nation's boards of pharmacy.

John McHugh, president of Retired Persons Services, Inc., Alexandria, Virginia, and his capable staff were open and candid with me when I visited them. They provided me with a great deal of material that is included here. I appreciate the courtesies they extended me and I believe we demonstrated that individuals can disagree without being disagreeable. Steve Honigman, legal counsel for Retired Persons Services, was invaluable in advising me of some of the jurisprudence associated with mail service pharmacy.

William L. Marcus, deputy attorney general for the state of California, gave me much wisdom and great guidance in developing the report. My visit with him and with Lorrie Garris Rice, director, and Bob Hertzberg, public member, respectively, of the California Board of Pharmacy, made their own special contributions. I am indebted to Bob Johnson, director of the California Pharmacists Association, Margaret E. Jost, vice president of legal affairs and John Berger, president of the CPA for their generosity in sharing the wealth of information they had in store.

One of my most rewarding visits was with the National Association of Boards of Pharmacy. Executive Director Fred Mahaffey, along with Jack Atkinson, had a comprehensive and understanding appreciation of many of the issues involved with the subject matter of this report.

John Rector, National Association of Retail Druggists, provided me with a great deal of historical background concerning mail service pharmacy and, because of his past association with the U.S. Senate, gave me an insight into the federal considerations of this pharmacy specialty.

Finally, I must express my appreciation to the President, Sal D'Angelo, the Executive Director, Howard Bolton, and the members of the Louisiana Board of Pharmacy for their confidence in assigning this report to me. I can only hope that the final product justifies their faith.

ED REED
Baton Rouge, LA
June, 1986

DEFINITION OF TERMS

The practice of selling and delivering prescription drugs from a vendor in one state to a customer in another state is commonly referred to as "mail order pharmacy."

The term is not entirely accurate, since there are other methods of delivery and business solicitation besides the use of the Postal Service to deliver pharmaceuticals across state lines. There are common carriers who regularly deliver prescription drugs. With the increased use of television shopping, where the viewer sees drugs advertised and calls a toll-free number and the drugs are delivered by common carrier, there is no contact at all with the postal service.

Because of the defectiveness of the term, other terms have come into vogue and all of these terms are used interchangeably through the following report.

Those operating pharmacies which solicit, advertise and sell across state lines seem to prefer the term "Mail Service Pharmacy" to "Mail Order Pharmacy." This term is used extensively throughout this report. "Out-of-State Pharmacy" is a term which seems to be more accurate, although not entirely so. To a pharmacy in New York state, a pharmacy that operated in Louisiana would constitute "out-of-state" pharmacy, whether it had any operations in the state of New York or not. "Interstate Pharmacy" is used by some and this certainly is an accurate description. Several states dealing with mail order have used the term "Extraterritorial" pharmacy and this is probably a legitimate description, although it conjures visions of capsules and tablets dropping from outer space.

When any of these terms are used in this report, the reader should understand that the use of the mails to deliver prescription drugs is incidental, optional and probably irrelevant to the subject treated. We are talking about the movement of prescription drugs from a point in one state to an ultimate consumer in another state.

HISTORY OF MAIL ORDER

The movement of goods and services by mail, common carrier and other modes is a logical outgrowth of a type of selling called "direct marketing." The name is intended to imply that the procedure eliminates the middleman--wholesaler, distributor or retailer--from the marketing process and replaces the intermediary with a direct relationship between producer and consumer. However, in truth, the mail order proprietor or vendor has simply inserted himself in the traditional role of middleman, replacing the wholesaler, distributor or retailer, unless the mail order service is also the manufacturer of the product being sold. This is rarely the case.

The roots of direct marketing began in Europe as it emerged from the Middle Ages and feudalism and entered the Renaissance. The earliest catalogues produced were probably those dealing with seeds and nursery items, which date back as early as the 14th century. In fact, mail order seed houses in America (Burpee, Park, Harris, Stokes, Gurney and others) have been in existence for more than a century.

The first trade catalogues were those issued by printers soon after Gutenberg's invention of moveable type in Strasbourg, Germany about 1450. Most of the early catalogues in Europe dealt with books and other literary works for sale.

In America, it was in the post-Civil War period that catalogue sales began to emerge as a strong marketing force. This was an era when Populism was gaining strength and farmers, along with other rural Americans, began to seek ways to buy goods more cheaply. The National Grange, an organization of farmers, built a membership of almost half a million and adopted the mail order slogan based upon the concept of mail order referred to in the opening paragraph: "Eliminating the Middleman."

The strongest impetus for direct marketing came as a result of the innovativeness of two pioneers in American selling, Aaron Montgomery Ward and Richard Warren Sears.

About 1872 Ward established a relationship with the National Grange and produced a one-page list of items that ranchers and farmers could buy directly from him in Chicago. That list is generally considered to be the first full-fledged mail order catalogue.

In 1886, Sears, a young railroad station agent chanced upon a package of watches sent by a Chicago jewelry merchant which was refused by the intended recipient. Sears offered the watches to other railroad agents along his line and was gratified by the response. By 1900, he was well into the catalogue sales market, overtaking Montgomery Ward and never relinquishing that lead.

The two merchants were soon joined by other mail order houses such as J. C. Penney, Spiegel and Aldens.[1] Mail order was, for a long time, a rural phenomenon. City dwellers generally had stores nearby but this luxury was denied those in smaller towns. Moreover, automobiles were not in general use and the only alternative for rural citizens was to use the mails or await the appearance of the itinerant peddlers who roamed the countryside. However, as mail order obtained greater sophistication and variety in the merchandise offered the customer, it was embraced by many who lived in the larger cities.

Mail order pharmacy probably began in America about the same time that Ward and Sears began the general practice of catalogue selling. In the more developed eastern section of the United States railroads were used to transmit the mail from place to place. On April 3, 1860, mail service began operations between St. Joseph, Missouri and San Francisco. In some areas steamboats were used to transmit mail.

Rural free delivery was established in 1896 and the parcel post system was inaugurated in 1913, giving impetus to mail service deliveries.

Today mail order is a well-established marketing technique. It is estimated that 2-1/2 billion catalogues are sent to Americans who care to shop at home and this group will buy something like $40 billion worth of merchandise through the mail. So sophisticated has the procedure become that even the term "mail order" is archaic. More and more people are using toll-free telephone numbers. Technology could even make the catalogue obsolete. Many sales are being made using home computers or interactive television.

Perhaps the greatest single boost to mail service pharmacy came in 1946, when the Veterans' Administration began the distribution of prescription drugs to its clientele. The VA was followed in 1959 by the National Retired Teachers Association and the American Association of Retired Persons.

According to Edward H. Clouse, PhD, mail service pharmacies got a gratuitous boost at the controversial "Kefauver investigation" hearings conducted by Senator Estes Kefauver of Tennessee in late 1959 and early 1960. Clouse reports that the hearings inadvertently became a source of national publicity for the the mail order pharmacy concept. The publicity, according to Clouse, "resulted in the proliferation of mail order prescription companies throughout the country and particularly in the nation's capital."

Life magazine devoted an article to the Kefauver hearings entitled, "Big Pill to Swallow," detailing the money savings that were possible from mail order pharmacies.[2]

Today there are probably dozens of mail service pharmacies scattered throughout the nation. It is virtually impossible to locate all of them, because there is no type of central registry for this type of entrepreneur, although there is an association, of sorts, of some of the major mail service pharmacies.

FOOTNOTES

1. Direct Mail Marketing Association: *A History of Direct Marketing*; *Consumer Reports*, October, 1983.

2. Edward H. Clouse: *The Voice of the Pharmacist*, January, 1985.

CONFLICT AND CONFRONTATION

Mail service pharmacy has been described as "a potential time bomb that could redirect the manner in which pharmacy services are provided."[1]

And, in 1986, there is ample proof that the fuse on that time bomb is sputtering closer and closer to the explosive. More than half the boards of pharmacy in the nation are in the process of regulating mail service pharmacy or are looking with interest at the possibility of exercising some kind of regulatory powers over out-of-state pharmacies which use the mails or common carriers to ship prescription drugs to their states. With the increased popularity of catalogue sales, it was inevitable that mail service pharmacies would eventually carve out their own market. This market would necessarily be realized out of the share of market enjoyed by the traditional pharmacies, i.e., independent community pharmacies and chains.

How much of the total prescription drug market has been claimed by mail service pharmacies is unknown. As is to be expected, proponents of the practice tend to minimize the number of prescriptions filled while walk-in pharmacies would, understandably, tend to overstate the magnitude of the market.

The largest mail service pharmacy in existence is the Veterans' Administration Pharmacy Service. In fiscal year 1984, approximately 43 million prescriptions for ambulatory patients were dispensed from 227 pharmacies. In addition, over 285 million patient medication doses and approximately 10 million intravenous and total parenteral nutrition solutions were prepared and distributed. Acquisition costs for drugs and pharmaceuticals exceeded $469 million.[2]

A spokesman for the VA told me the ratio of mail service prescriptions to walk-in prescriptions was roughly half. Using this as a guide, during 1984 the pharmacy service would have dispensed approximately 22 million prescriptions by mail or common carrier.

The second largest mail service pharmacy in the nation is the AARP Pharmacy Service, a service of the American Association of Retired Persons.

AARP estimates the number of prescriptions it dispenses at approximately seven million. The service estimates that the total of all prescriptions dispensed by all mail order pharmacies is less than three per cent of the total number of prescriptions dispensed throughout the nation.

It has been estimated that approximately 1.5 billion prescriptions are dispensed yearly in this nation and, if we use AARP's three percent figure, this places the yearly total of mail order prescriptions dispensed at approximately 50 million.[3]

The conservative estimate arrived at by AARP would seem to be supported by others, notably the Wall Street Journal, which estimated in its January 15, 1986 edition that mail order drugs account for approximately $100 million of the $19.4 billion a year retail market for prescription drugs.

But regardless of the amount of the market claimed by mail service pharmacies at the present, there seems to be a consensus that the market will continue to grow and it is only a question of time before the share of market reaches sizeable proportions. And, if the past growth is any harbinger of the future, that time is not far away.

In 1969, according to an HEW task force, the VA dispensed slightly more than four million prescriptions by mail. During the intervening 15 years, the traffic multiplied more than five times over, to the aforesaid 22 million prescriptions. In 1968, AARP dispensed

4,000 prescriptions daily by mail. Five years later that volume was upped to 6,000 daily--a 50 percent increase.

This rapid growth of mail service pharmacy seems to be the rule, rather than the exception, among firms. Some examples: The Health Insurance Plan of Greater New York, in 1968, filled 50,000 prescriptions. In 1971 it dispensed 270,000. Pastor's Pharmacy in Philadelphia tripled its business in one year. Federal Prescription Service, Inc., of Madrid, Iowa, within six years, became one of the largest businesses in the state in terms of income from postal operations.[4]

The pharmacy changed its name to America's Pharmacy and has tabulated an astounding record of earnings. In 1981, the company had total revenues of slightly over $5 million. Four years later, in 1985, earnings skyrocketed to $74 million. In 1984, the company had $367 million in annual sales and expects that figure to leap to an estimated $1.6 billion in 1988.[5]

Medco, a mail service pharmacy, says it filled three million prescriptions in its fiscal year ended June 30, 1984, a 30% jump from the previous year. Moreover, there are additional companies entering the mail service field. Late in 1985, Sears, Roebuck & Co. began offering mail order drugs through Mature Outlook, Inc., a membership club for the elderly. J. C. Penney was already in the business through its Thrifty Drug Co. division.

Hospitals are beginning to enter the field. In the summer of 1985, the not-for-profit Rush Presbyterian-St. Luke's Medical Center in Chicago began a mail order drug program through a for-profit subsidiary, ArcVentures Inc. One of the company's customers will be the City of Chicago, which plans to buy mail order drugs for 40,000 current and retired employees. [6]

And the list goes on: Comp-U-Card, out of Stamford, Conn., is offering an electronic shop-at-home service with approximately one million subscribers whose members can charge prescriptions via VISA cards; Ford Motor Company, General Motors, Uniroyal, Chrysler Corp. and others have jumped into the field.

A spokesman for Pennsylvania's American Federation of State, County and Municipal Employees (AFSCME) estimated in 1984 that only five percent of the prescriptions filled for that state's public employees fund are mail order, although he expects the ratio to climb eventually to 20 percent.[7]

As the competition grew more heated, so did the tempers of opposing forces: the mail service operators on the one hand and principally the independent pharmacies on the other. Although some chain pharmacies are being affected to some degree, some of the larger chains seem to believe that "if you can't beat 'em, join 'em." Several major chains -- Revco, Peoples and Hook Drugs -- are among them.

There is currently a war of words going on between mail service pharmacies and independents. Sometimes the voices become strident and restraint goes by the boards. Mail service operators have complained about some of the literature disseminated by opponents, some featuring skull-and-crossbones and other graphic symbols designed to frighten users of mail service pharmacy.

But the mail service pharmacies get in a few licks of their own, charging that pharmacists are disseminating false information as part of a "well financed, well orchestrated propaganda campaign based on innuendo and blatant misinformation." The AARP has charged that, "while community pharmacist groups claim their greatest concern is for the public health and welfare, they are most interested in their pocketbooks. But this is nothing new..."[8]

This is not to say that spokesmen for community pharmacists have been role models of moderation. A leaflet produced by the National Association of Retail Druggists trumpets this loaded question: "...do you really want to bargain away your health?" It adds, "Do you really want to give all this up--the quality of your own health care--to save a few dollars?"

And, while sticks and stones may break one's bones, words will not really cause a great deal of damage. So it was inevitable that the battle would leave the rhetorical arena and begin to be fought in the courts and the legislative halls.

While there have been several efforts to force the issue in the courts, there has never been a judicial determination that addresses the central question: do states have the right to regulate the activities of those pharmacies outside its borders shipping prescription drugs to points inside the borders of those states? The various states have used legislation, attorney generals' analyses and opinions, rules and regulations and varying interpretations of their laws and regulations but the fact remains that there has never been a court ruling that says, "Yes, states can exercise jurisdiction" or, "No, the states are prohibited by the Commerce Clause of the Constitution from exercising such jurisdiction."

The positions of proponents and opponents of the question are incredibly simple. Those favoring prohibition of states acting to regulate mail order pharmacy take the position that such action is contrary to the Commerce Clause and is, therefore, unconstitutional. They point out that mail order pharmacy services which are properly licensed by the state in which they are domiciled have met regulatory requirements and that to expect these enterprises to register in additional jurisdictions would constitute an undue burden on them and, hence, violate the Commerce Clause. They further suggest that these attempts to extend the state's regulatory powers smack of protectionism and are not truly in the public interest.

Boards of pharmacy, on the other hand, point out that their charge is to protect the public health and welfare. It is impossible for them to live up to their charge as long as there are drugs entering their jurisdiction of which they have no knowledge. They further claim that pharmacies seeking to render service to the public at the lowest possible cost would seek out those states which have the least restrictions and domicile there, circumventing the more rigorous requirements of states which attempt to regulate pharmacy strictly.

There have been several efforts to resolve the matter in the courts but most of these efforts have simply skirted the issue and the outcome has not been definitive.

The state of California at one time, prior to 1966, sued a mail order pharmacy in Kansas City named

Getz, to force compliance with the state's law but the case was never tried. No one really seems to know today many of the facts involved in the case.

One case in 1973 involved the state of Iowa vs. Rasmussen concerning the legality of Iowa pharmacists filling prescriptions written by out-of-state practitioners. It was determined that Iowa could not prohibit pharmacists in the state from filling prescriptions from outside prescribers.

Other cases have involved the question of how far a state can go in involving itself in regulating parts of interstate commerce but, for the most part, there is no definitive precedent available that says clearly that a state can mandate the licensure and regulation of out-of-state pharmacies shipping filled prescriptions into the state.

As a result, the only guideposts that present themselves are contained in the opinions and analyses of state attorneys general, usually written at the request of state boards of pharmacy. Individually, these writings are clear in pointing out the extent to which states can inject themselves into the areas of interstate commerce. However, collectively, they only tend to confuse the subject even more because some of them contradict others.

Most of these opinions and analyses are of recent origin, which probably indicates the impatience of many of the states with the status quo and a desire to bring the mail order issue to a head.

Ohio

One of the very early opinions (No. 82 032, dated May 4, 1982) bears the signature of then Ohio attorney general, William J. Brown. The opinion was issued at the request of the Ohio State Board of Pharmacy and posed three specific questions:

1. Is the solicitation of orders and mailing of dangerous drugs to residents of the state of Ohio the "sale" of drugs in the state of Ohio...and, as such, subject to regulation by this Board?

2. Are the activities of mail order retail pharmaceutical distributors, in advertising and promoting their retail goods through the mails to Ohio consumers, "advertising"...and, as such, subject to regulation by this Board?

3. Is a third-party payor who, pursuant to a contract with a mail order retail pharmaceutical distributor, pays the distributor for "dangerous drugs" provided to the third-party payor's beneficiaries, a "purchaser" of dangerous drugs who must be licensed?

The ruling from the attorney general held that "(1) Out-of-state mail order retail pharmaceutical distributors, engaged solely in interstate commerce, are not subject to regulation by the Ohio Board of Pharmacy...; (2) An out-of-state mail order retail pharmaceutical distributor, engaged solely in interstate commerce, may not be prohibited...from advertising its interstate business in Ohio... and (3) Ohio third-party payors who pay out-of-state mail order retail pharmaceutical distributors for drugs provided to the payors' beneficiaries are not engaged in the sale of drugs and need not be licensed as 'terminal distributors of dangerous drugs'...." The opinion declared that "...the retail pharmaceutical distributors, which are foreign corporations and which sell drugs through the mails, such drugs being shipped from another state for delivery in Ohio, are engaged in interstate commerce."

Brown's opinion cited a number of legal precedents, including the aforementioned Rasmussen case. It noted that "...even though state regulation of mail order pharmaceutical distributors serves a legitimate public interest and is evenhandedly applied, it appears that the burden certain regulations would impose on interstate commerce could outweigh the benefits derived therefrom." (Emphasis supplied.)

Brown advanced these criteria to be used in determining whether a state regulation is inconsistent with the Commerce Clause of the Constitution:

1. Does the regulation serve a legitimate local purpose?

2. Does the statute regulate evenhandedly with only incidental effects on interstate commerce?

3. Does the regulation affect an area which requires a uniform national policy?

Wisconsin

On August 23, 1983, Wisconsin Attorney General Bronson C. LaFollette issued an opinion (OAG 33-83) to the Wisconsin Department of Regulation and Licensing in answer to a query from Barbara Nichols, secretary of the department. Three questions were asked:

1. Does chapter 450 (of the pharmacy code) authorize the Pharmacy Examining Board to extend its licensing and registration requirements to out-of-state pharmacies which solicit mail order sales from Wisconsin residents?

2. Does the regulation of an out-of-state pharmacy by the Wisconsin Pharmacy Examining Board, whether pursuant to a specific statute or based on an implied legislative mandate, establish an unconstitutional burden on interstate commerce?

3. If it is assumed that out-of-state pharmacies may dispense prescriptions by mail to Wisconsin residents without being licensed, must the pharmacies nevertheless comply with the other provisions of chapter 450 regarding the dispensing of prescription drugs?

In a five-page opinion, the attorney general held in the affirmative regarding the first two questions posed and found that the answers to the first two questions negated the need for an answer to the third.

LaFollette found that although the pharmacy law did not explicitly require out-of-state pharmacists to be licensed or regulated, "an implied power to regulate them when they solicit orders from Wisconsin residents may be inferred from the statute." LaFollette's conclusion concerning any possible burden on interstate commerce was directly opposite from Ohio Attorney General Brown's the year before: "I conclude, therefore, that in balancing the strong interest of Wisconsin in regulating the sale of prescription drugs from out-of-state pharmacies to state residents against the incidental effect of the regulation on interstate commerce, there exists no undue burden on such commerce."

LaFollette continued, "...the courts have uniformly held that a state may enact safety regulations under the police power in the interest of the public health and welfare....In more specific terms, the regulation of pharmacies has been recognized as a legitimate exercise of the state's police power to act for the protection of the public health and general welfare."

However, LaFollette cautioned that "significant practical problems are often presented in enforcing state laws against out-of-state firms. These practical problems should be carefully considered before the Department undertakes enforcement action against an out-of-state pharmacist."

(As if in fulfillment of a prophecy, the Wisconsin AG's office declined to handle the initial case generated by the Wisconsin board and the board is presently trying to prevail upon the district attorney of the county involved in a mail order transaction to handle it.)

Kansas

Less than a year later, the Kansas attorney general's office responded to a query by the attorney for the Kansas Board of Pharmacy by concluding in its opinion Number 84-71 that "...both the language and purpose of the Kansas Pharmacy Act require that out of state pharmacies doing business in Kansas hold a Kansas pharmacy license and be subject to all Kansas regulations."

The opinion concerned itself strictly with an interpretation of Kansas pharmacy law and made no concession to the Commerce Clause of the Constitution. It suggested simply, "In none of the foregoing statutes is there any language of limitation which suggests that only Kansas residents are subject to the board's control....the language of the Kansas Pharmacy Act does not suggest that its provisions are limited to pharmacies within this state."

California

About three months following the Kansas ruling, William L. Marcus, deputy attorney general of the state of California, issued an analysis in response to a request to California State Board of Pharmacy Executive Officer Lorrie Garris Rice that affirmed the board's power to require licensure of out-of-state mail order pharmacies and its power to regulate the condition of drugs and devices which are sent into California by such pharmacies.

The analysis reached the following conclusions:

1. Mail order pharmacies are "doing business" in California.

2. There is no impermissible burden on interstate commerce by such licensure and regulation. Citing the 10th Amendment to the Constitution, which reserves to the states the powers not delegated to the federal government or specifically prohibited to the states, Marcus commented "this has repeatedly been interpreted to reserve broad police power as to a state's health, safety and welfare. This is particularly recognized as to health professions..." Marcus noted that the Commerce Clause does not forbid burdens being imposed unless they are undue burdens. According to Marcus, the current test of a state regulation's validity is found in Pike v. Bruce Church, Inc. (1970): "Where the statute regulates evenhandedly to effectuate a legitimate, local public interest and its effects on interstate commerce are only incidental, it will be upheld unless the burden imposed on such commerce is clearly excessive in relation to the putative local benefits."

3. There is no denial of due process or equal protection. Marcus pointed out that "...out-of-state distributors are treated essentially the same as in-state licensees" and there is clearly no denial of equal protection.

4. There is no preemption on the part of Congress. Clearly, the federal drug laws are intended to set minimum national standards, not uniform requirements. Marcus concluded, "...the whole scheme of federal regulation in the area of drugs indicates the field has not been preempted from the states."

Nebraska

Although Marcus concluded that the burden on interstate commerce by requirements of licensure and regulation was minimal, six months later the attorney general of the state of Nebraska, in opinion 57, authored by Deputy Attorney General A. Eugene Crump, held that "...the state's interest in regulating the flow of controlled substances is adequately protected by the pertinent federal statutes. Consequently, it is our opinion that LB 578 (requiring licensure and regulation) is of suspect constitutional validity under the Commerce Clause of the United States Constitution."

Crump had no problem with the board's legislation meeting most of the requirements contained in the litmus test provided for in the Pike v. Bruce Church case. Yes, the state clearly has a strong and legitimate local interest; yes, it appears to regulate evenhandedly. However, that portion of the Bruce Church criteria which states that the effects of the state regulation on interstate commerce "must only be incidental" caused him concern.

Finally, the opinion holds, state attempts to regulate interstate commerce which may be considered as simple economic protectionism are virtually invalid on the face of it. Hence the finding that the attempt by the Nebraska legislature to enact a mail order statute was of "suspect constitutional validity under the Commerce Clause."

Mississippi

One of the most recent legislative actions occurred in the state of Mississippi following passage by that state's legislature of a bill to regulate "extraterritorial" pharmacies doing business in Mississippi. Among the requirements listed in the bill for mail service pharmacies to operate in Mississippi was the maintenance of a 24-hour toll free Wide Area Telephone Service (WATS) line to "facilitate communications between the patient and a pharmacist licensed in this state who shall have access to the patient's prescription records as maintained by the extraterritorial pharmacy."

Mississippi Governor William Allain vetoed the bill, Senate Bill 2546, because of this requirement, citing the provisions of the Pike v. Bruce Church, Inc. case. The chief executive concluded that the even-handedness of the legislation was flawed by requiring out-of-state pharmacies to maintain the WATS line when it had no such requirement for domestic pharmacies.

Delaware

The Delaware Office of Narcotics and Dangerous Drugs (ONDD) requested that the state's attorney general review the Delaware Pharmacy Act to determine the validity of the board's requiring out-of-state pharmacies to register. Edward F. Kadafer advised the board in November, 1983 that it would be necessary to seek a legislative change in the pharmacy law before the board could require registration.

In 1985 the ONDD again contacted the AG's office for an updated opinion and was told that it should amend the Delaware pharmacy law "to specifically empower the board to require such (mail order) pharmacies to obtain a pharmacy permit." Deputy AG Kafader cautioned, "Even if legislation were enacted which would specifically require out-of-state pharmacies to obtain a pharmacy permit prior to dispensing in this state, there are potential legal problems possible."

Louisiana

Louisiana passed a law requiring mail service pharmacies to register with the board of pharmacy in the summer of 1985. An opinion was requested of the attorney general's office concerning the validity of the law and on November 7, 1985, in Opinion Number 85-837, Chief Counsel of the office, replied. In what is undoubtedly the shortest opinion on mail service pharmacy (less than 300 words), the office stated that the law was "merely an express restatement of what the existing law impliedly prohibited. We can find no constitutional fault in Act 216 under either the Commerce Clause of the United States Constitution or under any other state or federal constitutional provision."

Several excellent analyses of the overall mail service situation have been made by Richard A. Angorn, R.Ph, J.D. and Kevin S. Cannon, R.Ph and, while these may not have the official ring accompanying expressions from elected public officials, they are nevertheless concisely stated and clearly explained. In a paper prepared for delivery at a pharmacy law seminar, the pair wrote:

"...Historically, matters concerning public health, including the prescribing and dispensing of prescription drugs, have been regulated by the states through the exercise of their police power. In an informal opinion, the Department of Health and Human Services (HHS) has made it amply clear that the issue of prescription regulation, insofar as who may be authorized to prescribe and dispense prescription drugs, is one which is left solely to the states....Therefore, state laws which prohibit the filling of out-of-state prescriptions are not unconstitutional."[9]

The pair offers a kind of "do it yourself" kit for determining the constitutionality (or the lack of it) in any state legislation:

"When analyzing the constitutionality of state legislation affecting interstate commerce, three questions must be addressed:

"#Does the state regulation constitute economic protectionism?

"#Is the local state interest and the effect of the regulation outweighed by the burden or impact on interstate commerce?

"#Is there a reasonable alternative available for the state to achieve the same goals with a lesser burden or impact on interstate commerce?

"If the answer to any of the foregoing questions is in the affirmative, then the state legislation will be unconstitutional as violative of the Commerce Clause of the U. S. Constitution."[10]

The question of whether mail order legislation runs contrary to the Commerce Clause of the Constitution is clearly the overriding one in determining whether any attempt by a state to regulate mail order pharmacy will stand or fall. If it is found that legislation of this type does violence to the clause, all other arguments in favor of regulation fall of their own weight.

FOOTNOTES

1. Angorn and Cannon: "Mail Order Pharmacy," U.S. Pharmacist, July 1985, pp. 63-64.
2. Veterans Administration: Annual Report, 1984.
3. American Association of Retired Persons: June 1985 Prescription Drug Catalogue.
4. Drug Topics, February 19, 1974.
5. Caremark: 1985 Annual Report.
6. Wall Street Journal, January 15, 1986.
7. Martha Glazer: "Mail Order: Separating Facts from Fiction," Drug Topics," February 6, 1984.
8. AARP Drug Catalogue.
9. Angorn and Cannon: "Mail Order Prescriptions: THE LEGAL ISSUES," presented to the American Society for Pharmacy Law, San Antonio, Texas, February 19, 1985.
10. Angorn and Cannon: "Mail-Order Prescriptions," U.S. Pharmacist, July 1985.

AND NOW! THE HORROR STORIES

Proponents of mail service pharmacies believe the principal reason for opposition to the practice is economic and is prompted by the competitive realities of the marketplace. Because, they argue, mail service pharmacies offer distinct savings over the traditional walk-in community pharmacy service, community pharmacy opposition is prompted principally (or perhaps, solely) by the cash register.

While there is no question that mail service pharmacies offer stiff competition to traditional pharmacies, it would be inaccurate to lump all opposition to mail order operations under the marketplace umbrella. There are other arguments that are as valid as the economic argument.

There are some pharmacists who maintain that mail service pharmacy is unsafe by its very nature. The patient is deprived of the face-to-face consultation with pharmacists, has to wait long periods of time for needed medication and is exposed to the hazards of transporting drugs long distances with very few controls to insure that they will not be tampered with or affected by the elements.

In 1972, the chairman of the Judicial Board of the American Pharmaceutical Association (APhA) expressed the opinion that pharmacists practicing in mail order pharmacies must be presumed to be engaged in unprofessional conduct in violation of certain sections of the APhA code of ethics. In the early 1970s, mail order pharmacies were accused of unknowingly filling forged prescriptions because of the inability to know the prescribing practices of local physicians.

Writing in the Michigan Pharmacist, Eddie L. Boyd reported these incidents:

#A package of medication was left in a seldomly used doorway of a home without the required signature needed for delivery. The patient felt that the package had been tampered with and had difficulties obtaining replacements from the mail order company.

#One patient mailed a prescription for Valium to be filled and received Nolvadex (an anti-cancer drug) from the mail order pharmacy.

#One pharmacist had to open his store on a Sunday afternoon to dispense an emergency supply of anti-hypertensive medications to a former patient who had switched to a mail order pharmacy and did not receive her medication refills before her supply ran out.

#The problem most frequently associated with mail order prescription services appears to be delays in the delivery of medications; leaving the patient without adequate supplies of maintenance drugs.[1]

Most boards of pharmacy maintain that their interest in regulating mail service pharmacy springs simply from the charge they have been entrusted with safeguarding the public health and safety. How can a board of pharmacy, they ask, fulfill its obligation to the citizens of a state when there are large quantities of drugs entering the state about which the board has little or no knowledge, much less control?

This latter contention is the one held by most of the pharmacists and pharmacy leaders contacted in the preparation of this report. Although there were numerous instances of "horror stories" available to document the belief that mail service represented a threat to the public health and welfare, many of these were anecdotal in nature and did not represent any reflection upon mail service in general. In fact, many of the directors of the boards of pharmacy were complimentary in their comments about the professionalism characterizing the pharmacy service of the better-known mail order firms, particularly the AARP Retired Persons Pharmacy Service.

Nevertheless, the record is replete with examples of mail service prescription mistakes that could conceivably have jeopardized the health and safety of patients.

A litany of near misses involving mail order prescription errors was unfolded by NARD President Joseph Schutte. Included among them:

A 72-year-old female received a mail order prescription for 40 milligrams of Lasix and .25 milligrams of Lanoxin tablets. Both tablets are round and white and when the patient dumped them onto her kitchen table to count them, she inadvertently returned the Lasix to the Lanoxin container and vice versa. The dosage of the Lanoxin was one tablet every other day; the Lasix prescription called for one tablet twice a day. The result was digitalis intoxication because the patient ended up taking four times the prescribed Lanoxin dose. She developed nausea, vomiting and weakness, which was diagnosed as an intestinal virus. The physician had no reason to suspect digitalis toxicity since the drug was prescribed on an every other day schedule. The error was discovered by a community pharmacist when a request for a premature refill was submitted.

A 70-year-old patient had three mail order prescription errors within a one-year period. Each time the problem could not be resolved over the phone and the patient had to return to the mail order dispensing site to correct the situation--a convenience not available to most mail order customers. In one instance, the patient received the wrong medication, even though her name was indicated on the prescription.

In one particularly alarming situation, a 67-year-old patient with myasthenia gravis received a mail order prescription for Mestinon. The patient insisted the doctor write the prescription for 100 tablets to be refilled five times. But myasthenia gravis is a progressive disease and an effective initial dose is a less effective dose later. The result was a dramatic underdosage over time and the patient's rapidly debilitating health. The underdosage resulted in a progressive loss of muscle control until it became necessary to admit her to a nursing home. Action by the pharmacist resulted in a consultation among the pharmacist, physician and patient that restored the proper drug therapy.[2]

In the same article, Schutte writes, "A recent account from a former mail order employee suggests the existence of deplorable practices in some mail order houses, such as losing or duplicating controlled substances, filling over 3,000 prescriptions a day, non-pharmacists taking prescription orders over the phone and validating them and mailing the same prescription out as two separate prescriptions--one generic and one brand name."

In 1974, hearings were held before the Subcommittee to Investigate Juvenile Delinquency of the Senate Committee on the Judiciary. Inserted into the record were several examples of mail order mistakes that read like something out of a James Bond spy-versus-spy thriller.

Testimony by Sal Robino, then director of the Pharmacy Society of the state of New York, revealed that he deliberately forged a prescription for 100 Tuinal capsules, sent it off to a Philadelphia mail service pharmacy and got the prescription back filled with no questions asked. "The prescription was filled," says Robino, "even though it bore no physician's identification number as required by the Bureau of Narcotics and Dangerous Drugs. And the firm didn't contact the physician to get the number for authentication."[3]

In the same citation, Pennsylvania authorities, employing state police as phony mail order customers for dangerous drugs, sent four prescriptions each to 16 mail order houses both in and out of the state. Nine firms, including six that were out-of-state, returned a total of 2,000 pills running the gamut of uppers and downers from Carbrital and Butisol to Desoxyn and Desbutal. None of the prescriptions were questioned, none of the phony doctors on the prescriptions were contacted and, according to the testimony, "most amazing of all, the firms were so anxious to make the sales they didn't bill the participants for several weeks." The total bill came to $130 and in the illicit drug trade the returned prescriptions could have been marketed for $1,000.[4]

It should come as no surprise that those associated with mail service operations do not concede that the trade is racked with uncertainty and mistakes. One of the principal and most articulate advocates of mail service is John McHugh, president of the American Association of Retired Persons Pharmacy Service. In testimony before the aforementioned Senate Judiciary subcommittee, he made a case for the integrity of mail service pharmacies, comparing the record of mail service pharmacies in prescription fraud cases with that of community and chain pharmacies, referred to by McHugh as "walk-in" pharmacies.

"Retired Persons Pharmacies, during their 15 years of existence, have experienced no robberies or thefts nor any known instances of fraudulent prescriptions, other than the ones perpetrated in the course of investigations by regulatory and licensing agencies," McHugh asserted.

The Drug Enforcement Administration (at the time the Bureau of Narcotics and Dangerous Drugs), according to McHugh, concluded that "mail order prescriptions are not a significant source of diversion."

McHugh and the AARP point to the conclusions reached in Project Script, a study of prescription fraud vulnerability conducted by the Bureau of Narcotics and Dangerous Drugs of the U. S. Department of Justice, which attempted to determine (1) the ease with which prescription fraud is perpetrated, (2) the prevalence of prescription fraud and (3) remedies for combatting prescription fraud.[5]

According to John Ingersoll, BNDD Director, who commented upon the Bureau's findings in 1972:

"...In response to...allegations made in 1969, the Bureau conducted an investigation of mail order pharmacies and concluded at that time: The findings do not lend credence to the suspicion that mail order prescription firms are a major source of diversion for controlled drugs. On the contrary, the level of compliance with the Drug Abuse Control Amendments of

1965 compares reasonably well with the general run of prescription pharmacies.

"The Bureau is concerned with the relative ease that controlled substances are obtained from all pharmacies. But this problem is not confined to mail order houses, as shown by a New York Daily News survey last spring. Generally, it would appear that drug abusers are more likely to select a retail pharmacy rather than a mail order pharmacy to attempt to pass a forged prescription. Their needs are of an immediate nature and are more quickly satisfied through a fast purchase. Safety is also a factor. Abusers do not want to give a return address to a mail order house and prefer doing business with a local pharmacy. The abuser can watch the pharmacist's reaction to a forged script and quickly leave if the pharmacist goes to the telephone..."[6]

Mail order advocates such as McHugh point to Project Script as proof positive that mail service pharmacies are actually safer than their community counterparts. Hear this statement to the Senate committee:

"I think we would all be better served in trying to see what we can do to minimize the vulnerability which was pointed out in DEA's survey, Project Script. I am not at all proud that mail service pharmacies were found to have a 25 percent vulnerability as compared to community pharmacies' 56 percent vulnerability. All of us can do better."

There are entries on both sides of the ledger regarding the safety and integrity of mail service pharmacies. It is probably not as chancey as opponents maintain or as foolproof as supporters trumpet. The truth is somewhere in between. Certainly errors happen in community pharmacy just as they happen in mail service pharmacy.

But there are differences in kind between the two disciplines that add an element of risk to mail service pharmacy. This risk is minimized in the case of the more professionalized services such as AARP but they exist with some mail service operations that could best be described as marginal. The fact that they also exist, to a degree, with community pharmacy does not argue against the need for regulation and licensure of mail service pharmacies because, after all, community pharmacies are all licensed in the area in which they operate, while most mail service pharmacies are registered only in the areas in which they are domiciled, leaving a never-never land that exists without surveillance, without regulations and without licensure.

Much criticism is leveled at mail service pharmacies because of the absence of the pharmacist-patient relationship.

Many mail service pharmacies go to great length to compensate for the distance between dispenser and patient. In 1974, AARP official John McHugh told the Senate subcommittee:

"...Virtually every mail service pharmacy, including our own, heavily utilizes WATS lines to verify prescriptions for controlled substances. In our Washington, D. C. pharmacy alone we have ten fulltime people, including a chief pharmacist, who do nothing but contact physicians around the country to verify prescriptions. The phone bill for the Washington pharmacy alone is approximately $4,000 a month.

"Separate inspections of prescriptions by different pharmacists, practitioner signature comparisons, membership numbers and spot checks of prescribers of controlled substances are among the other procedures employed by these pharmacies to authenticate prescriptions."

It is certainly true that the major practitioners of mail order pharmacy go to great lengths to insure that the patient's health and welfare are protected but detractors of the industry maintain that these fall short of adequate safeguards.

According to one critic of the profession:

"Proponents of mail order prescription services contend that patients can save money because of the increased buying power of those operations. The author (Edward H. Clouse, PhD) feels, however, that a lack of adequate patient counseling and drug monitoring may result in the improper usage of prescription medications, giving rise to such problems as drug interactions, increased drug-related hospitalizations and prolonged drug therapy. The outcome of such problems may be an increase in the individual patient's overall health care costs. The above problems can only be exacerbated by the possibility of a delay in receiving medications through the mail.

"Most mail order prescription services have not, up to the present, maintained patient profiles and have provided only written information to the purchasers of prescription drugs. Many studies have indicated that written information should be used only as a supplement to, not a replacement for, oral communication between the patient and the health care professional. Without proper screening of medication profiles and drug regimen consultation, the incidences of drug interactions and noncompliance, especially among the elderly, will inevitably increase."[7]

Community pharmacists place a great deal of emphasis on the physician-patient-pharmacist interaction and feel that anything that interferes with this tripartite relationship interferes with adequate drug therapy. Former NARD president James H. Vincent believes that this relationship is most critical with that segment of the population that makes the greatest use of mail service drugs: the elderly. According to Vincent, "While it is true that a much greater percentage of prescriptions for older patients are long-term drugs, it is also true that the same patients are most in need of the services that only the local pharmacy can provide." Vincent believes that mail service, by its very nature, cannot provide this interaction and concludes that interaction and patient consultation are "most effectively carried out by personal observation and consultation."

Vincent believes that the local pharmacists are frequently the only source of both the prescription drug and over-the-counter medication and "that important consultation is much more likely to occur in that environment than with a mail order pharmacy."[8]

The elderly patient is at the heart of the dispute between supporters and detractors of mail service pharmacy and it is interesting that the biggest guns of the "anti's" are trained on this market while the practitioners of mail service pharmacy point with considerable pride to their record of service to this constituency.

It is an often demonstrated fact that the elderly are the greatest consumers of prescribed medicines. Most authorities estimate that persons 65 and older use twice the number of medicines as adults between the ages of 25 and 54.[9]

In a previously-cited article, Dr. Edward Clouse concludes:

> "...Those who are 65 or older now constitute 11 percent of the total expenditures in the area of health care and 25 percent of the expenditures made on drugs. They also represent 39 percent of the population in acute care hospitals and 90 percent of those now in long term care. These older people may be taking many different medications while under the care of several physicians who may not coordinate their prescribing practices for chronic diseases. Obviously, the risk of adverse drug interactions is increased under such circumstances. The screening of medication profiles for drug interactions and other medication related problems is essential for coordinating the prescribing of drugs for elderly patients. These profiles should also be consulted by the pharmacist when an elderly patient purchases an over-the-counter drug."

Clouse cites studies that point to the dangers of non-compliance with instructions when the elderly are involved. One study, Clouse reports, "found that 24 percent of their subjects were confused or incorrect about the purpose of their medication. In another study, compliance was found to decrease as the number of medications increased. The rate of compliance ranged from an average of 65 percent with one drug to 47 percent with six drugs...."[10]

Mail service advocates meet the criticisms concerning their inability to provide face-to-face counseling head on. They question whether such counseling is routinely provided by community pharmacies. AARP Executive Director Cyril F. Brickfield has provided statistics aimed at refuting the claim that community pharmacy provides any better personal consultation than mail service.

In a testy rebuttal, Brickfield charges:

"(In a) scientific study conducted by AARP in 1982, more than 1,000 adults, aged 45 and older, were interviewed about their prescription drug use. Regarding pharmacist consultation at walk-in pharmacies, we found that for those over 65: 1.46% are *never* told by pharmacists the name of the drug; 2.53% *are never* told by pharmacists the condition for which it *is prescribed*; 3.27% are *never* told by pharmacists how to take the drug; 4.55% are *never* told by pharmacists how to store the drug; 5.62% *are never* told by pharmacists about the drug's side effects.

"...Walk-in pharmacists are claiming wonderful benefits for those customers who do business with them....There is no doubt that some walk-in pharmacists do provide personal consultation but most of us know that the only personal contact we have in most pharmacies is with a cashier."

FOOTNOTES

1. Eddie L. Boyd: "The Controversy Continues," *Michigan Pharmacist*, January 1986.
2. H. Joseph Schutte, P.D.: "Mail Order and the Public Health," *NARD Journal*, June 1985.
3. Senate Judiciary Committee, March 26, 1974, Appendix 17, p. 426, reprinted from *Drug Topics*, February 19, 1973.
4. Ibid.
5. Dr. Albert A. Glass, Special Agent Kenneth G. Goodman and Dr. Sidney W. Hinkley: *Project Script*, BNDD ca. 1969.
6. John Ingersoll: Address at the annual meeting of the National Association of Retail Druggists, Chicago, October 4, 1972.
7. Edward H. Clouse, PhD: "Mail Order Prescriptions: Consumer Convenience or a Cause for Concern?," *The VOICE of the Pharmacist*, January 1985.
8. Letter from National Association of Retail Druggists President James H. Vincent: *NARD Journal*, September 1984.
9. Judith A. Kasper and Renate Wilson: "Use of Prescribed Medicines: A Proxy Indicator of Access and Health Status," *International Journal of Health Ser-*

vices, Volume 13, Number 3, 1983, pp. 433-442.

10. Clouse: "Mail Order Prescriptions: Consumer Convenience or Cause for Concern?"

11. American Association of Retired Persons Drug Catalogue, June 1985.

THE BOTTOM LINE: Does Mail Order Really Save Money?

In a definitive study some years ago, researchers Albert I. Wertheimer and James E. Knoben undertook to compile scientific data about the mail service pharmacy industry. A list of approximately 60 organizations was compiled and data were collected from interviews gained with a smaller sample of the 60. The researchers claim that the organizations studied account for approximately 90 percent of the volume of mail order prescription drugs dispensed in the nation.[1]

As could be expected, there is no consensus among protagonists in the mail service as to whether or not the system is cheaper than dealing with a local pharmacist.

Mail service operators point to several competitive edges they enjoy against the competition in the battle for the prescription dollar. One such advantage is the ability of pharmacists to concentrate upon the primary job of being a pharmacist.

A spokesman for AARP draws a graphic, although hardly esthetic, distinction between what their 125 registered pharmacists dispense and what they feel comes out of the community pharmacies. "(Our pharmacists) don't have to sell fertilizer or answer phones...we don't carry all that junk that other drugstores carry...."[2]

Even stronger language was used by AARP's John McHugh, who angrily charged before the Senate Judiciary

Committee, "Consumers are fed up with wide and unwarranted disparities in retail drug prices. Consumers are fed up with both physicians and pharmacists who often seem to function as selling agents for brand name drug manufacturers. Consumers are fed up with a manufacturer-physician-pharmacist fraternity that excludes them from every aspect of the drug delivery system, except to pay their bills."[3]

Mail service pharmacies explain that their prices are lower for the following reasons: buying drugs more cheaply because of volume purchasing; using lower cost generic drugs instead of brand name entities and dispensing larger quantities--usually three month supplies, but on some occasions six month supplies. This cuts down on the number of claims and the number of dispensing fees paid pharmacists. AARP president McHugh has estimated the savings by using generics at more than 50% on a list of 144 drugs (based on quantities of 100).[4]

Although these savings are legitimate ones and obviously serve to lower the price of prescription drugs, community pharmacists will not concede that the bottom line is sufficiently affected to realize genuine cost savings. Additionally, these are not true savings accomplished because of the nature of mail service as opposed to community or chain pharmacies. Physicians prescribe and they can write a prescription for a three-month supply that can be filled at a walk-in pharmacy just as readily as at a mail service pharmacy. Volume purchasing is not the exclusive province of mail service institutions. Chains consistently purchase in this manner, as do cooperatives and other buying groups formed by individual community pharmacies. Finally, every state in the nation has on its books variations of laws providing that pharmacists may substitute generics for name brand drugs in the absence of an outright prohibition by prescribers. In-state pharmacies can--and most do--readily fill prescriptions for generic drugs without prodding.

Moreover, community and chain pharmacies point to advantages enjoyed by mail service pharmacies that are not as legitimate or as pure as the examples cited.

Michigan pharmacist Eddie L. Boyd writes, "To date, there has been no published information demonstrating that mail order prescription plans provide overall savings to the companies that are encouraging their workers to use them." Boyd continues:

"...One of the purported benefits of mail order prescription plans is that the companies can allegedly save patients 30-50% on their drug costs. In advertising these types of savings the companies mislead consumers because they are normally comparing apples to oranges, e.g., comparing the costs of generic products dispensed by mail order pharmacies to the costs of brand name products dispensed by traditional pharmacies."[5]

Community pharmacists charge that some of the alleged savings in mail service pharmacy are realized by tactics not quite kosher. They point to a lower co-pay by third party payors for doing business with a captive or favored mail service pharmacy than the patient can realize from dealing with community pharmacist.

Some pharmacists have charged that one reason mail service pharmacies charge less than community pharmacists is the use of non-profit status to divert drugs from the traditional channels of pharmaceuticals from manufacturer to druggist. Mail service operators are not required to pay occupational license taxes and other taxes that vary from state to state. Mail service pharmacies collect no sales tax in many states and this, too, has an effect on the bottom line.

An estimate provided by the Louisiana Retailers Association charges that the state loses $50 million yearly in sales tax collections every year through out-of-state catalogue sales. This amounts to about a billion and a quarter dollars in sales dollars, the association estimates.

In the regular session of the Louisiana legislature in spring/summer, 1986, Representative Charles Lancaster introduced legislation to allow the state an opportunity to recoup sales taxes from catalogue sales. The bill passed the House 77-17 and was sent to the Senate for further action. Lancaster's estimate was that the state was losing between $65 and $80 million in sales tax revenues on $1.6 billion in out-of-state catalogue purchases.[6]

Nationally, the Advisory Commission on Intergovernmental Regulations (ACIR) has recommended to the Congress that mail order firms be required by federal law to collect state use taxes on interstate mail order sales where the firm engages in regular sales solicitation through advertising, catalogues or other means. The organization estimates that the total loss to state and local governments since an unfavorable 1967 Supreme Court decision has been almost $1.5 billion.

Wertheimer and Knoben classified mail service pharmacy services into four groups:

1. Nonprofit government, such as the Veterans Administration.

2. Nonprofit private, such as the AARP.

3. For-profit companies offering specialized and limited programs, such as the Western Medical Company, which caters to the drug needs of epileptic patients.

4. For-profit, open, public drug programs, with no membership or other categorical requirements.

Most mail order pharmacy services offer walk-in as well as mail service services. As a rule, they dispense prescription and non-prescription drugs as well as vitamin pills and limited sundry items. Most dispense Schedule II prescription drugs, although they will, as a rule, focus on "maintenance drugs" prescribed for such long-term ailments as heart disease and high blood pressure. These drugs are estimated to account for about[7] 80 percent of prescription drug expenditures.

FOOTNOTES

1. Wertheimer and Knoben: "The Mail-Order Prescription Drug Industry," *Health Services Reports,* November 1973, kVol. 88, No. 9, pp. 852-855.
2. *Wall Street Journal*, January 15, 1986.
3. Testimony before the Subcommittee to Investigate Juvenile Delinquency of the Committee on the Judiciary, U. S. Senate, 93rd Congress, March 28, 1974.
4. Martha Glaser: "Mail Order Rxs: Separating

Facts from Fiction," Drug Topics, February 6, 1984, pp. 43-44.

5. Eddie L. Boyd: "The Controversy Continues," Michigan Pharmacist, January, 1986.

6. Louisiana Retailer, April 1985; Baton Rouge Sunday Advocate, June 15, 1986, "Bill to recoup taxes on catalog sales approved."

7. Wall Street Journal, January 15, 1986.

THE PAST IS PROLOGUE:
Executive Summary and Analysis

Earlier in this paper there was a reference to the analogy used by researchers and authors Angorn and Cannon terming mail service pharmacy "a potential time bomb."

The analogy is well directed.

In preparing this report, most of the boards of pharmacy in the United States were contacted and an abbreviated analysis of their responses is contained farther along. It is clear that something will have to give because more and more states are concerning themselves with the system of pharmacy that utilizes the mails, common carriers and other means of transmitting drugs from seller to buyer, crossing state boundaries in the process.

Many who are observing this phenomenon are concerned that the federal government may move into this area and pre-empt the field, preventing any regulatory action by the states. If states are to establish themselves as regulatory bodies for out-of-state pharmacies it will be necessary for them to come to agreement on a number of the details associated with such regulation.

At present there is little agreement among the states as to procedure in licensing and regulating the practice of mail service pharmacy and it is unlikely that there will be any such consensus. The National Association of Boards of Pharmacy is working on model legislation to recommend to state boards but there are boards who continue to direct their efforts toward passing their own legislation within their own jurisdictions.

If all boards of pharmacy were to adopt identical legislation, it is possible that federal action would be prevented but existing laws do not interface among the states and are often inconsistent, if not contradictory. According to Angorn and Cannon:

"...At present, some states: (1) recognize only intrastate prescriptions as valid, (2) recognize as valid prescriptions from bordering states and foreign countries, (3) recognize certain types of prescriptions from any state or country, (4) prohibit mail order solicitation and (5) license out-of-state pharmacies which do business in the state." (Paper delivered by Angorn and Cannon to the American Society for Pharmacy Law, San Antonio, February 19, 1985.)

It has yet to be determined whether a state can, under the Commerce Clause of the Constitution, regulate mail service pharmacy. For virtually every ruling, opinion or analysis that tends to support the states' rights to do this, there is a corresponding and opposite statement that opposes these rights.

It seems to be axiomatic that a court test will be the arbiter, barring Congressional action.

Several states have come close to a court test but to date none has materialized. In California, as was covered earlier, the state board of pharmacy moved to require licensure of a Kansas City mail service firm by the name of Getz. The case, however, disappeared into a kind of Twilight Zone, was never tried and few in California seem to remember any of the details.

Perhaps the state of Arkansas has come closest to testing the right of states to regulate out-of-state pharmacy. The board of pharmacy filed suit against a mail service firm operating outside Arkansas selling drugs to Arkansas residents. A confrontation was avoided when the organization dealing with the out-of-state pharmacy cancelled its agreement with the pharmacy and the matter became moot.

It would seem that the first thing that must be established is whether or not states have any jurisdiction at all over pharmacies located outside their borders. Any regulations or procedures mandated understandably fall of their own weight if the state is prohibited by the Commerce Clause from involving itself in interstate commerce.

Certainly there are other questions that must be answered if mail service pharmacies are to be regulated but the central question of jurisdiction must be answered first. This is the predicate upon which all other considerations must stand.

Without attempting to delve into legal issues, this author must confess his bias in favor of state boards of pharmacy having some control over the drugs purchased and used by their citizens or they cannot effectively do the job for which they were created. How they do this is quite another matter. There is sufficient precedent for establishing ground rules guarding against economic protectionism, minimizing the burden on interstate commerce and conforming to the other conditions discussed earlier in this report.

The Commerce Clause does not prohibit any state from involving itself in matters related to interstate commerce. This, it seems, has never been considered to be in violation of the law. However, no state can impede interstate commerce and this is understood.

In the matter of drugs, laws change from jurisdiction to jurisdiction. A few years ago the legislature of the state of Louisiana considered a bill to place the drug methaqualone in Schedule I, which would have had the effect of establishing criminal penalties for its possession. The neighboring state of Texas schedules methaqualone in Schedule II.

Had the bill passed, it would have meant that a patient in Shreveport, Louisiana, being treated by a Dallas physician, having had methaqualone prescribed by this physician and filled by a registered pharmacist in Texas, could have been arrested and sentenced to a term at hard labor in Louisiana once he crossed the border.

Perhaps this is an extreme example but "Louisiana only" Schedule II drugs are carried in a special category within the state. These drugs are carried in other schedules in other states of the nation.

The federal government has taken a hands-off attitude concerning the states classifying drugs in schedules other than those maintained by the DEA. The stipulation is that states must not be less stringent in classifications. There is no prohibition against adopting more stringent classifications.

Nor is the area of drugs the only one where states have regulated around the Commerce Clause of the Constitution. The Wisconsin attorney general's opinion clearing the way for that state to police mail service pharmacy pointed out that collection agencies are regulated in some states.

Insurance is handled by the individual states and most require that insurance companies appoint registered agents, post bonds and abide by state law. It may be that insurance is singled out by Congress for special treatment but this does not alter the fact that the states handle this field in their own ways.

Anyone who uses a gasoline or other credit card can attest to the fact that interest rates are a kaleidoscopic jumble of numbers that read like a railway timetable. The annual percentage rate varies from 12% to 21%. The periodic rate ranges from 1% to 1.75%. Some states assess this rate to all charges; other states have different balance limitations. Some states have a minimum finance charge of $1.00. Others have .50 and .70.

States have traditionally policed their borders for exotic importation of fruits and vegetables and, in some cases, have prohibited the passage of questionable commodities.

It would seem that state concerns with the quality and type of pharmaceuticals delivered to citizens would clearly qualify for legislative action because of the immiment threat to the public health and welfare involved.

But even if the question of jurisdiction were to be resolved in favor of the rights of states to regulate out-of-state pharmacies, there are many road blocks ahead for jurisdictions who broaden their scope to include pharmacies outside their borders. Any such regulations must be carefully drawn to prevent any hint of protectionism or any desire to place an undue burden on mail service pharmacies that would tend to give a competitive edge to in-state pharmacies. Here are a few questions that will have to be answered:

How does a board of pharmacy locate mail service pharmacies doing business within the board's jurisdiction? In every single instance where boards are attempting or actually handling regulation, there is no systematic or orderly procedure for locating pharmacies outside state lines. Leads are obtained in the most primitive sense, through the grapevine, by complaints (from recipients and competitors) and by accidental intelligence.

What does a board do about inspections? If a board is to undertake an actual physical inspection of an out-of-state pharmacy, the cost would be substantially higher than the cost of inspecting an in-state pharmacy. Can the board pass along this added cost? It has been suggested that the in-state board could enter into a reciprocal arrangement with the out-of-state board in which the mail service pharmacy is domiciled and the inspection report provided to the in-state board. But what happens if, say the Arkansas Board of Pharmacy requests a sister state to inspect a mail service pharmacy domiciled in that state and the requirements of the sister state are less stringent than the state of Arkansas. Can the inspector from the sister state's board inspect for items not included in its state's pharmacy code?

Who or what do you license? Do you license the pharmacist or the pharmacy? Or do you license both? If a mail service firm does business in all 50 states, does it have to be licensed in all 50 states? If it has five pharmacists filling prescriptions without regard for the ultimate geographical delivery of the medicine, does the mail service firm have to license each of the five pharmacists in all 50 states for a total of 250 licenses? Will it additionally have to license its pharmacy in all 50 states?

Can the state require that the mail service pharmacy meet some requirements that are not imposed on domestic pharmacies? Governor Allain of Mississippi vetoed Mississippi's mail order bill because it required out-of-state pharmacies to maintain a 24-hour WATS line and did not require this for in-state pharmacies.

How about patient profiles? Some states seem to be including in their planning for mail service regulation the mandatory maintenance of profiles. If this is required of out-of-state pharmacies it will mean that many states will have to mandate this for local pharmacies. This will probably not prove to be popular with those pharmacies ill-equipped to maintain such profiles.

So, even after states have been given judicial sanction to regulate out-of-state pharmacy (should this ever occur) there are still knotty and complex problems to be solved, a few of which have been touched upon here.

Here is what states are presently doing:

ACTION BY THE STATES

ALABAMA: Has a law providing for the licensure of out-of-state pharmacy. Those pharmacies it has located have complied with state law requiring registration. The board of pharmacy is presently awaiting NABP's development of agreement between boards before inspecting the pharmacies. The state refers to the out-of-state providers as "extraterritorials" and requires the pharmacy, rather than the pharmacist, to register. Rule No. 7 of the Alabama board does, however, require that each such pharmacy "shall furnish proof that at least one pharmacist registered in Alabama is a regular full-time employee." Alabama also requires pharmacies to document the fact that they are in good standing in their domiciles.

ALASKA: The state has discussed mail order at board meetings but has drafted no regulations. Because of a budget crunch, the board of pharmacy has only one meeting a year. Its interest in involving itself in mail service pharmacy is heightened by the state's weather problems, which include rapid freezing and their concern is that mail service pharmacies "have to understand that you just don't ship drugs to Alaska by UPS."

ARIZONA: The state attorney general's opinion 71-28-L states that there is contact sufficient to warrant the licensing by Arizona of out of state pharmacies. It does not license any pharmacy outside the state and the board has never addressed the subject.

ARKANSAS: The law providing for the licensure and regulation of mail service pharmacies was passed in 1983. Presently only a single Tampa, Florida-based pharmacy is registered. The board of pharmacy initiated legal action against a mail service pharmacy in Missouri but the case became moot when the Arkansas client, the Farm Bureau, cancelled its contract with the pharmacy.

The state plans to inspect pharmacies.

Arkansas has moved farther into the realm of regulating mail order pharmacies than any other state and the action has been prompted by what the board considers to be possible dilution of the Arkansas pharmacy law by allowing those outside the state to circumvent it. Board secretary Lester Hosto comments, "We have a concern about the drug distribution system. We feel that we have good pharmacy law in Arkansas. It is stricter and more rigid than many other states and offers our people a measure of protection that other states don't. We simply do not feel that we should subject them to inferior standards of care because a mail order firm has domiciled itself in a state which has more relaxed laws than we do."

CALIFORNIA: The board of pharmacy decided, at one time, to attempt to ban outright mail service pharmacy but was unsuccessful in convincing the legislature that there was sufficient cause for such action.

One of the early attempts at litigation, during the '60s, involved a suit by the California board against a Kansas City mail order firm named Getz. The suit dragged on interminably and eventually vanished.

As mentioned earlier, there is an attorney general's analysis expressing the opinion that the state can license mail order pharmacy. The board has identified and located about 20 prospective licensees and is using the "power of persuasion" to convince them to register. The board was not willing, at the time this report was written, to attempt to license pharmacies or pharmacists. They were simply interested in determining if out-of-state pharmacies were in compliance with the rules and regulations of their own state. The board is awaiting with interest the model legislation currently being drafted by NABP.

CONNECTICUT: The state has no plans to regulate mail order pharmacies, although they do register out-of-state wholesalers, manufacturers and distributors. The state does not inspect wholesalers. Its authority to regulate is contained in a statute that provides that the commissioner of consumer protection, with the advice and consent of the pharmacy commission, may promulgate regulations relative to dispensing, defining the practice of out-of-state pharmacy and other matters.

There is one mail order firm operating out of Connecticut, AARP, which the board director termed "a clean outfit." However, a mail service firm attempting to domicile within the state in August 1985 was not approved by the board and the pharmacy moved out of the state.

FLORIDA: Has no regulation or law involving mail service pharmacy.

GEORGIA: The state has no specific statutory provisions regarding out-of-state pharmacy. However, it is the sentiment among the board that it has the authority under regulations to license and regulate these businesses and it is implied in Georgia pharmacy law. The state does have a law to prevent mail order pharmacies from operating within the state. The law provides that a pharmacy cannot routinely receive prescriptions through the mail and has been on the books for more than 12 years.

IDAHO: The state has an interpretation of an existing statute prepared by the board which is now awaiting an attorney general's review. The informal consensus is that mail service pharmacies who mail prescriptions into Idaho are, in fact, doing business in Idaho and therefore should be licensed in that state, but they will not act until the attorney general's ruling is received.

ILLINOIS: Illinois does not currently address the subject of mail order pharmacy and does not plan to do so.

INDIANA: Indiana law prohibits pharmacists in the state from filling prescriptions from out of state practitioners, but a bill is awaiting the governor' signature that would allow this. Their only stipulation for out-of-state pharmacies mailing into Indiana is that they comply with Indiana labeling requirements.

IOWA: The state does not regulate pharmacies who mail prescriptions into Iowa; nor do they restrict Iowa pharmacies from filling out-of-state prescriptions. America's Pharmacy (successor to Federal Prescription Services) is domiciled in Iowa. The Iowa vs. Rasmussen case determined that physicians who practiced outside of Iowa could have prescriptions filled in Iowa as long as the physician was duly registered under state-federal controlled substances acts in the state the physician practices in.

KANSAS: Kansas has an attorney general's opinion that allows it to regulate out of state pharmacies, and for the past year they have been preparing to do this, although no such pharmacies have yet been licensed in Kansas. They are seeking statutory support to back up this AG opinion, as some of these pharmacies have ignored their inquiries. Legislation will be filed in their 1987 session. They have located six such pharmacies doing business in Kansas and intend to license at least one pharmacist in each. They feel that if pharmacies doing business in Kansas from out-of-state are not required to abide by state law, then pharmacists who practice inside Kansas are being discriminated against.

KENTUCKY: Kentucky's board has been grappling with the mail order problem for some time. Their interest was sparked by a complaint from a Kentucky physician regarding a prescription sent to one of his patients. This physician went so far as to complain to the chief pharmacist at the mail order house, who "took it very lightly." A number of other complaints have also been filed. Kentucky feels legislation is necessary to enable them to act on licensing out of state mail order pharmacies.

MAINE: The state has no current laws or regulations regarding mail service pharmacy and does not plan to address the situation.

MARYLAND: The Maryland Board of Pharmacy introduced legislation at their 1986 session seeking the authority to license mail order pharmacies, but the bill did not pass. The bill would have required pharmacies who send drugs into Maryland to hold a nonresident permit and to be licensed in the state in which they are located, to maintain prescription records on Maryland patients in a readily retrievable manner, that they maintain a lawbook of Maryland regulations and formulary, and that toll-free telephone numbers be provided for patient counseling. Individual pharmacists would not have been licensed. They have talked to a few other states regarding reciprocity agreements but nothing has been determined. They do not yet know how to locate the names of mail service pharmacies sending prescriptions into Maryland, or if any mail order pharmacies are domiciled in Maryland.

MASSACHUSETTS: The state does not regulate out of state pharmacies; they feel it is the duty of the state in which the pharmacy is domiciled to regulate. Massachusetts pharmacy rules and regulations prohibit engaging in intrastate mail order business, and they also require that any pharmacy must be open 72 hours a week to serve the public, hence ruling out mail order firms. Their legal definition of a pharmacy is a duly licensed pharmacy in the state of Massachusetts. Because of this definition, nursing home patients are not allowed to do business with mail order pharmacies.

MICHIGAN: Michigan's licensing law provides that the board can fine, reprimand or suspend the license of any pharmacist who "employ(s) the mail to sell, distribute or deliver a drug which requires a prescription where the prescription for a drug is received by mail." But, according to the advice of the assistant attorney general, the board does not have the authority to go beyond its borders to enforce that regulation. As Michigan is a heavily industrialized state, mail order pharmacy business is presenting an economic problem; but there have not been enough abuses to justify regulation.

MINNESOTA: Minnesota has no laws or regulations pertaining to out-of-state mail order pharmacies and has no plans to regulate this.

MISSISSIPPI: In spring of 1986, the Mississippi legislature passed SB 2546 without a dissenting vote, but the governor vetoed it. The bill, which will be brought up again next year, provided for yearly inspections of out-of-state pharmacies doing business in Mississippi and for licensure of individual pharmacists in these pharmacies.

MISSOURI: The state does not regulate mail order pharmacy and does not plan to do so, although the matter has been discussed by the board. The Missouri Retired Persons Pharmacy in Kansas City is their largest in-state mail order pharmacy service; there may be others but they could not name them.

MONTANA: No laws or regulations currently cover mail service pharmacy. The Montana board is watching the actions of other states with interest.

NEBRASKA: The Nebraska attorney general rendered an opinion stating the board does not have the power to require licensure of out-of-state pharmacies sending prescriptions into Nebraska. The board is still studying the situation, but for now the matter is on hold.

NEVADA: Out of state mail order pharmacies are not licensed in Nevada. The two main ones are National Prescription Service of New Jersey and AARP. Abuses have been reported, but the Nevada board merely refers these problems to the state in which the pharmacy is domiciled.

NEW HAMPSHIRE: The Board feels it has no statutory authority to license pharmacies sending drugs into the state, although they are very concerned with violations of their pharmacy act that have been committed by such pharmacies. They have just begun licensing distributors and wholesalers and are looking at the possibility of doing the same with mail order firms.

NEW MEXICO: The state is currently gathering information regarding licensure of out of state mail order pharmacies, as they have had problems with outdated or misbranded prescriptions. They are not aware of any mail service pharmacies domiciled in New Mexico.

NEW YORK: Mail order pharmacies located in New York are licensed on the same basis as other retail pharmacies. (They could not name any such firms as these firms are not identified as mail order houses by the board.) Their board does not regulate out-of-state pharmacies as they have been advised this may be unconstitutional.

NORTH CAROLINA: In the 1960s, the board issued a "cease and desist" order to some national mail order prescription firms. Current pharmacy regulations absolutely prohibit licensing of pharmacies where prescriptions are primarily dispensed by mail. The North Carolina board does not feel it has the jurisdiction to regulate out-of-state pharmacies who mail prescriptions into the state.

NORTH DAKOTA: The board has received complaints regarding the length of time involved in receiving prescriptions through the mail, but doesn't want to get involved in licensing because of the "economics."

OHIO: An attorney general's opinion states the Ohio board has no jurisdiction over out-of-state pharmacies. A suit has been filed by the Ohio Pharmacists Association against the board, National Pharmacy and the attorney general to prevent any Ohio pharmacies from filling out-of-state prescriptions.

OKLAHOMA: Oklahoma law prohibits mail order pharmacies from locating in Oklahoma, but there are no provisions for out-of-state firms that mail drugs into the state. An attorney has been hired to research the situation.

OREGON: The Oregon board licenses only pharmacies located in the state. AARP is the only mail order house in Oregon, and is treated like any other retail pharmacy. Legislation was proposed recently to regulate out of state mail order pharmacies but was withdrawn. It will probably be reintroduced during their next legislative session.

PENNSYLVANIA: The board is currently studying their existing statutes to determine if they cover mail order.

RHODE ISLAND: The Rhode Island board has considered the problem of mail order pharmacy but has taken no steps toward regulating it.

SOUTH CAROLINA: South Carolina has one mail order firm in the state, Family Pharmaceuticals of Mount Pleasant (309 Mill Street, 29464), which is licensed as a retail pharmacy. While the board is very concerned about mail order and has considered the problem for several years, they have not yet determined an approach that will be effective and enforceable.

SOUTH DAKOTA: The board is concerned about the lack of control they have over pharmaceutical services provided their citizens by mail order firms and would like to have some control or surveillance of them. They are studying current laws and regulations to see if this is currently covered. The single mail order house in South Dakota is not involved in interstate commerce.

TENNESSEE: Many of Tennessee's major employers -- Uniroyal, Firestone, Snap-On Tools -- offer mail order prescription services as part of employee benefit packages. They are looking at the possibility of regulating mail order firms, the main ones being AARP, National Pharmacies (New Jersey) and Prescription Delivery Service (Pennsylvania). PDS was investigated by the Tennessee board when a patient complained about receiving 400 Zantac tablets at one time.

TEXAS: No statute or regulation currently addresses out-of-state mail order houses, but the Texas board has asked for an attorney general's opinion on the matter. AARP has a large outlet in Dallas, which is inspected just as any other retail pharmacy. The board is concerned that out-of-state firms mailing drugs into Texas meet the same standards as Texas pharmacies, but they do not yet know how this will be enforced. A higher fee for out-of-state pharmacies is being considered and they are awaiting the AG's ruling.

UTAH: The board is currently considering regulation of mail order pharmacy, although rules have not been drawn. They have received complaints by the elderly regarding the length of time involved in filling prescriptions by mail order firms.

VIRGINIA: Their board has no plans to address out-of-state mail order pharmacy, and they have no record of complaints about such pharmacies. AARP has a pharmacy in Richmond.

WASHINGTON: Washington does not regulate mail order pharmacy. They are considering licensing out-of-state drug distributors. Washington pharmacists are restricted by law to filling only prescriptions from Washington and its contiguous states (Idaho and Oregon). Mail order pharmacies located in Washington include Ellingson's Pharmacy (2505 Fifth Ave., Seattle, 98121) and Standard Drug (N. 1814 Division, Spokane, 99207).

WEST VIRGINIA: The state does not currently and does not plan to license out-of-state firms that mail drugs into the state.

WISCONSIN: An attorney general's opinion states the Wisconsin board can regulate out of state pharmacies doing business in the state. So far two of these are registered: Walgreen Arizona Drug in Phoenix and American Abbey Home Care in Rolling Meadows, IL. Many firms have ignored the board's correspondence; others have responded that they do not do business in Wisconsin. The board mails a statement to these companies asking if they comply with Wisconsin law, and licenses both pharmacy and pharmacist. Presently the board has a case against an out-of-state pharmacy, but their attorney general will not prosecute and the board is attempting to get the local district attorney to prosecute the case.

WYOMING: The board is analyzing current statutes to see if they can regulate mail order pharmacy without having to pass new legislation. They are awaiting advice from counsel and the attorney general.

EMENS, HURD, KEGLER & RITTER
A LEGAL PROFESSIONAL ASSOCIATION
CAPITOL SQUARE
65 EAST STATE STREET
COLUMBUS, OHIO 43215

TELEPHONE: (614) 462-5400
TELECOPIER: 464-2634
CABLE: LAW EHKR
TELEX: 246671

TIMOTHY J. BATTAGLIA
JACK A. BJERKE
JOHN P. BRODY
WILLIAM J. BROWN
JOHN I. CADWALLADER
STEPHEN E. CHAPPELEAR
J. RICHARD EMENS
LAWRENCE F. FEHELEY
JOHN L. GRAY
ALLEN L. HANDLAN
EDWARD C. HERTENSTEIN
THOMAS W. HILL
DWIGHT I. HURD
CHARLES J. KEGLER
LARRY J. McCLATCHEY
JOHN C. McDONALD
SAMUEL C. RANDAZZO
PAUL D. RITTER, JR.
ROGER P. SUGARMAN
KEVIN L. SYKES
JOHN R. THOMAS
JOHN B. TINGLEY
MELVIN D. WEINSTEIN
BEATRICE E. WOLPER
JEANNE K. WOODRUFF
MICHAEL E. ZATEZALO

JOHN F. ALLEVATO
WILLIAM A. FULLMER
STEVEN J. FUNK
GENE W. HOLLIKER
R. KEVIN KERNS
MICHAEL J. McNULTY
ANN M. O'CONNELL
MICHAEL G. O'KANE
HERBERT M. RICHARDSON III
STEVEN R. RUSSI
RICHARD W. SCHUERMAN, JR.
MICHAEL E. SCOLIERE
S. MARTIJN STEGER
MICHELE TOWBIN
RICHARD H. VETTER
GEORGIA VLAHOS

ROBERT D. MAROTTA
S. NOEL MELVIN
WILLIAM W. MILLIGAN
JOSEPH M. MILLIOUS
COUNSEL

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A WHITE PAPER

THE FACT VS. FICTION CONCERNING THE MAIL SERVICE PRESCRIPTION DRUG CONCEPT

BY: ROBERT D. MAROTTA, ESQ.
REGULATORY COUNSEL
MEDCO CONTAINMENT SERVICES, INC.

The mail service prescription drug concept has been roundly accepted in the pharmacy marketplace as an innovative alternative means of dispensing prescription drugs. The economic aspects of the concept aside, Medco Containment Services, Inc. ("the Company") has established an enviable record of dispensing the right drug, to the right person, in the right dosage, and at the right time. Indeed, in all jurisdictions in which the Company operates, those entities charged with the regulation of the practice of pharmacy, i.e., Boards of Pharmacy, have accepted and recognized the Company as a responsible member of the professional pharmacy community. Nonetheless, the impact of the mail service prescription drug concept, particularly when viewed by the traditional retail pharmacy lobby in terms of lost revenues, has given rise to a number of emotional, subjective, and economically motivated criticisms which, at best, can only be described as fictions. The Company, through its formalized regulatory program, has, and shall continue to, oppose the introduction of these fictions as a proper basis for the promulgation of burdensome and overly restrictive regulation. By way of general summary, these fictions and the factual responses to the same, may be described as follows:

Fiction No. 1: The mail service pharmacy operates in violation of state licensing laws requiring the licensure of retail pharmacies.

Fact: Each of the Company's mail service pharmacies is licensed by the state in which it is located. Each facility is in full compliance with all applicable state and federal laws and regulations.

The legal propriety of mail service prescription drug programs is based on the position that such programs are subject to regulation only by the state in which the dispensing facility is located and, of course, applicable federal regulation. For example, if the dispensing facility servicing a program for a client in the State of New Jersey is situated in Tampa, Florida, then the program and the practice of pharmacy thereunder would be subject to regulation by the State of Florida and by all applicable federal regulations. The mail service pharmacy would not be subject to regulation by any of the states outside of Florida into which it dispenses prescription drugs.

This position is based upon time-honored concepts and principles of Constitutional law. It is a general rule, applicable to all jurisdictions, that a corporation, such as a mail service pharmacy, which contracts for the shipment of its goods into another state is engaged in interstate commerce. The Commerce Clause of the Constitution of the United States of America gives to the United States Congress the power to regulate interstate commerce. If the United States Congress has exercised its power to regulate a specific aspect of interstate commerce, the ensuing federal regulation pre-empts further state regulation.

In the alternative, even if one were to take the position that a state is not pre-empted from regulating that aspect of the interstate flow of controlled substances already subject to federal regulation, the attempt of any state to regulate other than the state in which the dispensing facility is located would be found to be inconsistent with, and otherwise prohibited by, the Commerce Clause of the Constitution of the United States.

The position that mail service pharmacies are regulated by the laws of the state in which the dispensing facility is located and by federal regulation has met with great support by those people who are charged with the proper enforcement of the law. Attorneys General in many states have written formal Opinions supporting this position, and Boards of Pharmacy in those and other states have likewise agreed that local licensure is inappropriate. Most recently, some states, such as Florida have worked closely with the Company, the AARP Pharmacy Service and others to promulgate legislation which serves to regulate mail service pharmacies in a manner short of local licensure but nonetheless viable in purpose and effort from both a professional and constitutional standpoint.

Fiction No. 2: The mail service pharmacy deprives the various states into which it dispenses prescription drugs of sales tax revenues and other monies which would otherwise go to local pharmacists.

Fact: The sale of prescription drugs is, in most states, exempt from the imposition of sales tax. All of the Company's mail service prescription drug programs are in large part restricted to the sale of prescription drugs only. Of course, the payment of monies by a program sponsor to a pharmacy located out-of-state does have an impact upon local pharmacists. On the other hand, local pharmacists are free to avoid this result by offering prescription drugs for sale in a cost effective manner. In the meanwhile, sponsors who participate in the mail service prescription drug concept will continue to save monies that can be used to improve, and in many cases increase, the prescription drug therapy and other related health benefits available to its beneficiaries.

Fiction No. 3: The mail service prescription drug concept is susceptible to drug abuse, forged prescriptions, etc.

Fact: The Company's mail service pharmacies employ a dispensing process which has historically, and by a long proven record of performance, limited the possibility of drug abuse/misuse. This is accomplished through (a) an eligibility program to prevent the dispensing of drugs to persons who are not eligible to receive this benefit; (b) the use of a patient profile system; (c) the implementation of a computer software program which identifies patterns of drug abuse or misuse, if any; and (d) the direct contact by one of the Company's pharmacists with the office of a prescriber whenever a prescription is incomplete, unclear, or questionable in any other way.

The Company's pharmacies keep a complete record of each prescription dispensed including the name and address of the person to whom it was sent. Additionally, the Company's pharmacies ship all Schedule II (controlled) drugs via U.P.S. and require a signed receipt for delivery. Thus, the Company's rigid control system virtually eliminates the possibility of drug abuse or misuse.

Lastly, in response to considerable pressure exerted by pharmacy groups such as the National Association of Retail Druggists, the Drug Enforcement Administration designed a study to compare mail service pharmacies with traditional walk-in retail pharmacies in terms of forged prescriptions. The results of this study, known as "Project Script" and conducted on a national basis with the expenditure of substantive amounts of time and monies, concluded that retail pharmacies were twice as likely to pass forged prescriptions for controlled substances as mail service pharmacies. The conclusion set forth in "Project Script" remains unchanged by any other competent study.

Fiction No. 4: The mail service prescription drug concept is susceptible to drug diversion.

Fact: The Company's pharmacies purchase all of their medications (brand-name and generic) only through reputable sources, and dispense mail-service prescriptions only to eligible members of benefit plans. The Company never buys non-approved drugs, diverted drugs, or samples. The consulting medical director and the Corporate Pharmacy Director monitor all drug purchasing and inventory control procedures.

More specifically, the Company's pharmacies obtain their prescription drugs from manufacturers or authorized distributors who are duly licensed, industry recognized, and known for proper business and professional practices.

Internal Company controls then prevent the possibility of drug diversion. To date, the history of drug diversion in this country has been evidenced only by prosecutions, at the retail level, of traditional retail pharmacists and pharmacies. These prosecutions have produced no allegations or charges against the Company or other entities engaging in the mail service prescription drug business.

It is important to note that the Subcommittee on Oversight and Investigations of the U.S. House of Representatives' Committee on Commerce and Energy ("the Dingell Committee") has recently called upon the Company's recognized experience and expertise in the prescription drug dispensing area to assist the Dingell Committee in preventing drug diversion through the promulgation of federal legislation.

Fiction No. 5: The mail service prescription drug concept is susceptible to dispensing errors, lost prescription drug orders, etc.

Fact: There has been no evidence to date that the mail service prescription drug provider is any more susceptible to dispensing errors, lost prescription drug orders, etc., than the traditional retail pharmacy. In fact, the evidence points to the contrary. A recent study, dated June 2, 1986 by The Center for Pharmacy Management and Research at the University of Tennessee College of Pharmacy, entitled "Evaluation of Consumer Opinions of Prescription Drug Services From Community and Mail Order

Pharmacies," concluded that "(m)ost mail order users report few problems and the overall rating of the service was excellent or good. In fact, the rating for mail order services was slightly better than the rating for community pharmacy services."

The study showed that the dispensing errors experienced by mail service users was 0%, as opposed to 5% for traditional retail pharmacy users. As to the question of lost prescription drugs, the experience rate of these mail service users was 0%. Likewise, as to claims of tampering, the mail service experience rate was 0%. Indeed, when the authors of the study asked these mail service users if they planned to continue in their respective programs, the answer was 100% in the affirmative. The same question posed to traditional retail pharmacy users showed less than 100% satisfaction with retail pharmacies.

Fiction No. 6: The mail service prescription drug concept destroys the traditional pharmacist-patient relationship.

Fact: The Company's mail service pharmacies utilize dispensing procedures which provide the same characteristics of consultation as those found at the traditional retail pharmacy level. The Company maintains patient profiles and checks each prescription against the patient's drug history file and our sophisticated adverse drug reaction program. Pharmacists review and resolve any potential problem before medication is dispensed. The Company also includes drug information leaflets with more than 50% of the drugs dispensed. These leaflets, written in easy-to-understand language, provide the patient with general information about the medicine as well as specific advice on proper usage, possible side effects, and precautionary measures. It is important to note that the retail drug industry helped defeat proposed federal legislation that would have required them to use these leaflets (called patient package inserts) which the Company routinely uses.

Interestingly enough, a recent study presented to the National Council of Patient Information and Education contained survey evidence to the effect that drug information leaflets, in the opinion of the overwhelming majority of those retail pharmacists questioned, satisfy the pharmacist's professional responsibilities and fulfill the patient's needs.

Although the very nature of the mail service prescription drug concept prevents an actual face-to-face forum for consultation, the comprehensive nature of the consultation provided by the Company in written form, coupled with the use of the patient profile system and the availability of a registered pharmacist accessible through a toll-free (800) telephone line, probably raises the level of consultation in the Company mail service setting to a higher degree than that found in the traditional retail pharmacy.

Further, the Company has found through an independent study that the consumer-patient is more interested in the economics of his or her prescription purchases than the issue of consultation. Accordingly, that same consumer-patient may very well visit two or more pharmacies for prescription purchases, as opposed to the Company's consumer-patient, who satisfies his or her prescription needs at one central source.

Fiction No. 7: The mail service prescription drug concept employs inferior personnel and relies heavily upon the use of non-pharmacist personnel.

Fact: The Company employs only the very best pharmacists available. These pharmacists are professionals and they value the professional environment in each of the Company's facilities. They know the importance of the Company's quality-assurance programs such as patient profiles and drug interaction studies. They appreciate the fact that the Company frees them from non-professional duties so that they can devote themselves to the proper dispensing of prescription medication. Unlike retail pharmacists, they are not required to work unusually long days, nights, weekends, or holidays. All of these factors contribute to very high morale and a strong sense of professional pride among the Company's pharmacists.

To the extent that non-pharmacist personnel are employed, these personnel do not participate in the dispensing process, nor do they make any judgments of a professional nature. Non-pharmacist personnel only do those acts permitted by law and, in fact, in most cases do significantly less than their counterparts in the traditional retail pharmacy setting.

Fiction No. 8: The mail service prescription drug concept is susceptible to unreasonable delay in the receipt of prescription drugs, the breakdown of prescription drugs due to temperature extremes, etc.

Fact: The Company's mail service pharmacies dispense those prescription drugs which are known as maintenance drugs. Accordingly, and due to the manner in which the initial supply is prescribed, any brief delay in the receipt of prescription drugs is planned and managed by the patient and is therefore of virtually no importance. In fact, in the study cited previously by The Center for Pharmacy Management and Research at the

University of Tennessee College of Pharmacy, the occurrence of delay experienced by mail service users, as opposed to retail pharmacy users, was found to be the same. The Company historically processes at least 98% of its prescription orders within 24 hours of receipt. Of course, some prescription orders require additional information from the prescriber. These orders are normally processed within 48 hours of receipt. In either case, the mail service prescription drugs are delivered to the patient's home within seven to ten days from the time the patient mailed the prescription order.

Prescription orders are usually delivered via first class mail, except for a limited number of drugs that are delivered by United Parcel Service for receipt delivery. This latter group of drugs, i.e., Schedule II (controlled) drugs, comprise less than 1% of the Company's total prescription drug volume. All orders are presorted by geographical location so as to speed the delivery process and are delivered to major postal facilities throughout the day. The packages are designed to accommodate temperature variations and are shock resistant. Packages bear no indication that drugs are enclosed.

Mail service prescription drugs are exposed to no greater temperature extremes than these same drugs are exposed to when the manufacturer ships to the wholesaler and the wholesaler to the pharmacy, be it a traditional retail pharmacy or a mail service pharmacy. For example, many drug stores receive their pharmaceuticals via U.P.S. or overnight delivery using trucking methods that may expose drugs to fluctuations in temperature. Further, the same situations apply when these drugs are delivered by a clerk for a traditional retail pharmacy and left on the patient's doorstep, or when the patient picks up his prescription drug order at the traditional retail pharmacy and leaves it in the car, exposed to the elements, while he or she shops or does other chores on a very hot summer day or a very cold winter day.

Fiction No. 9: Pharmacists who fill prescriptions written by out-of-state practitioners are finding it increasingly difficult to obtain professional liability insurance.

Fact: The fact is that all of the pharmacists in the employ of the Company are covered by professional liability insurance and the coverage provided by such insurance is at least equal to, if not better than, that insurance carried by the traditional retail pharmacist. To the extent that professional liability insurance is an issue, the Company can honestly state that all of the pharmacists in its employ have coverage; this is not true of all traditional retail pharmacists.

Why then is this fiction even alleged? Although the Company does not know the specific basis for such an allegation, one can reasonably assume that this allegation is motivated by economic concerns based on the fact that mail service pharmacies compete with retail pharmacies for the maintenance drug market, and that it is intended to cause the Company's clients, and prospective clients, concern with respect to their contractual relationships.

Fiction No. 10: The mail service prescription drug concept has been roundly criticized by health care professionals and there exists a wealth of objective studies supporting such criticism.

Fact: The Company's major clients such as General Motors, United Technologies, all of the Ohio public retirement systems, the State of Florida, and the State of New York conducted exhaustive studies of the Company's pharmacy operations and the benefits of mail service before they implemented a mail service prescription plan. Many of these studies included reviews by medical advisors. In each and every case, the group was more than satisfied with its findings and enrolled its members in the Company's program. Since their enrollment, each of these groups has been gratified with the results of the program.

The only objective (third-party) studies which exist in this area are supportive of the mail service prescription drug concept. By way of example, consider some of the following major studies:

1. The Staff Report to the Federal Trade Commission, entitled "Prescription Drug Price Disclosures," issued in the late 1970's, wherein the Staff concluded, in pertinent part, as follows:

> After examining materials related to allegations that mail order pharmacies cause diversion of drugs, delays in patient medication, the destruction of bona-fide professional relationships and the demeaning of pharmacists by engaging in unlawful advertising, Staff concludes that such allegations are at best, vague, and more often, in conflict with the facts.

2. A study by Albert I. Wertheimer, Ph.D. and James E. Knoben, Pharm. D., "The Mail Order Prescription Drug Industry," Health Service Report, Vol. 88, #9, November, 1973, wherein the authors concluded, in pertinent part, as follows:

> The mail-order prescription drug industry appears to serve a real purpose by supplying the drug needs of patients who may be invalid, isolated, or in need of price savings otherwise unavailable. Further, this mode of practice is probably a permanent institution and will inevitably expand over time.
>
> While the alleged disruption of the physician-patient-pharmacist relationship and the potential for fraud in the mail-order industry are two issues worthy of discussion, the authors wonder whether a motivating issue might not involve the economic competition that a mail-order operation presents to the local retail pharmacist. There is no doubt that contending forces need to document their position.

3. The California State Board of Pharmacy (the "Board"), through the comprehensive efforts of a specially appointed study group consisting of Board members, to include a public sector attorney member, reported that the mail service prescription drug concept is a viable alternative means of dispensing prescription drugs, that there exists no credible evidence in the private or governmental sectors to the contrary, and that the Company, and others engaged in the concept, enjoy an earned respect in their home jurisdiction.

Therefore, the Committee made the following recommendations to the Board of Pharmacy as a legislative alternative in lieu of local licensure and consequent strict compliance with California pharmacy law and regulation:

A. All mail service pharmacies, located in a state other than California, must annually register with the Board. The registration would contain three (3) major requirements: (1) payment of a fee; (2) filing of Certificate of Good Standing from pharmacy's dispensing facility jurisdiction; and, (3) name and address of principal owners, officers, pharmacists, etc.

B. All such pharmacies must at least annually report to the Board that: (1) it maintains records of prescriptions dispensed to California patients in a readily retrievable manner; and, (2) records of prescriptions dispensed to California patients must be available to the Board through the Board in the pharmacy's home jurisdiction.

C. All such pharmacies must maintain during local hours of business operation a toll-free telephone number so that California patients have some level of consultation.

D. All such pharmacist must be subject to some sort of punitive measures if compliance with A through C is not had, e.g., revocation of registration, injunction to prohibit operations in California, etc.

Thereafter, Charles Cordry, Esq., the Acting Assistant Director of the Bureau of Competition at the Federal Trade Commission, was invited to speak on the issue. Mr. Cordry made the following comments:

A. The Federal Trade Commission ("FTC") looks at the regulations of any state by trying to evaluate the extent of which such regulations promote or restrict consumer welfare. There is a wide range of choices available to the consumer in the marketplace and these choices must be protected. Before restricting consumer choices, the proponents of restrictive regulation must demonstrate consumer harm.

B. In regard to mail service pharmacies, the FTC has heard a number of alleged justifications for restrictive-regulation. These justifications are essentially three (3) in number: the pharmacist-patient consulting relationship is impaired; there is potential for drug diversion; and, standards of quality cannot be maintained or enforced.

C. These alleged justifications are without merit:

(1) The pharmacist-patient consulting relationship is not impaired. Most of the drugs sold by mail service are maintenance drugs -- the benefits of consultation are already provided by the party primarily responsible for consultation, the practitioner. And, there are always means of consultation available -- toll-free telephone numbers with direct access to a pharmacist, package inserts, warning labels, etc.

(2) The potential for drug diversion is not justified. The DEA doesn't regard theft or forgery to be a problem. The United Parcel Service requires receipts (and Class II drugs are sent by such carrier). The Boards in several states are inconsistent in this regard -- most allow the mail to be used to deliver drugs on an intrastate basis, some allow taxicab drivers to do so.

(3) Concern that standards of quality cannot be maintained or enforced is misplaced. Other means exist. The Federal Controlled Substance Act already does this by regulating, among other things, the areas of inspection, packaging, record keeping, etc. Pharmacists who work in mail service pharmacies, and the pharmacies, are licensed in their home jurisdictions and subject to inspection.

Mr. Cordry closed his comments by saying that a case has not been made for heavy, restrictive regulation against mail service pharmacy when lesser means are available. The needs of protecting consumers can be accomplished/accommodated while maintaining consumer choice.

Thereafter, upon motion duly made, the Board adopted the recommendations of the Ad Hoc Committee on Mail Service Pharmacy.

(4) The Committee on Law Enforcement/Legislation of the National Association of Boards of Pharmacy, in its recommendations to the full Board on the issue of mail service pharmacy and the local licensure thereof, stated as follows:

> "In an effort to determine whether mail service pharmacy truly poses a threat to the public health and if, in fact, this is an area that needs regulation and is not solely an economic issue, the committee recommends that a survey be conducted to the state boards asking them if they have had complaints regarding mail service pharmacy, the general nature of such complaints, and any disciplinary actions that were taken. The results of this survey should be reported to next year's committee for a decision on whether any action is necessary," emphasis added.

JOHN R. MCHUGH, R.PH.
"MAIL ORDER PRESCRIPTION SERVICES: A PROVIDER PERSPECTIVE"

30TH ANNUAL OHIO PHARMACEUTICAL SEMINAR
FRIDAY, MAY 3, 1985
MARRIOTT INN - NORTH
6500 DOUBLETREE AVENUE
COLUMBUS, OHIO 43229

MAIL ORDER PRESCRIPTION SERVICE: A PROVIDER PERSPECTIVE

I have been asked to give you a provider perspective of mail service pharmacy and will approach this by discussing five general areas. First, a brief history of the mail pharmacy business, how it started, how long it's been around, who's in it, and its size compared with retail pharmacy. Second, will be an overview of the users of mail order pharmacy and their reasons for using it. Third will be a review of the services we provide our members. Fourth will be a discussion of reactions from FTC, DEA, and the postal service to allegations against mail service pharmacy. And fifth, an overview of legislative/regulatory efforts directly affecting us. I'll conclude with my perspectives on the future of mail service pharmacy.

There has been a lot of attention and publicity recently about mail order pharmacy and one might think we are the new kids on the block. In fact, however, the concept of mailing prescriptions has been around for years. Before the automobile, rural residents were often dependent on the U.S. mail to deliver medicines and health products from the local pharmacy. The practice was a convenience to the consumer and a service to the physician and pharmacist.

The group with the longest history of providing prescriptions by mail has been the VA which began this service in 1946, nearly 40 years ago. It was expanded greatly when veterans returned from

WWII and has continued to grow. The VA filled more than 19 million prescriptions in FY 83. The major difference between the VA and everyone else is that their medicines are provided free of charge to the patient. VA fills its mail-order prescriptions through 172 medical centers and 226 out-patient clinics. Eligibility for the service is determined by a review of the veteran's service record and a clinical assessment of the need for care.

We often hear complaints that mail order pharmacy is huge and is overtaking retail pharmacy. To give you a picture of how big we (mail order pharmacy) are--we represent less than 1% of the total market. If the 19 million prescriptions mailed by the VA are added to the figure, that ratio is only 2%.

For those of you who are unfamiliar with the AARP Pharmacy Service, we provide prescription and nonprescription and other health care items to AARP members. We are a nonprofit service filling more than 6 million prescriptions per year through eight regional mail service pharmacy centers and two walk-in facilities. We have been in existence for 26 years and are the largest private mail service pharmacy in the world.

We are not the only show in town however, and I'll explain the mail order prescription business by dividing us in four groups:

1. Nonprofit Government - VA
2. Nonprofit Private - AARP

3. For profit limited - serving such membership groups as the Arthritis Foundation, Epilepsy Foundation, Cystic Fibrosis Foundation, National Council of Senior Citizens, and National Education Association
4. For profit public drug programs - serving employee groups such as Chrysler, Ford Motor and the Ladies Garment Workers Union

Many of these organizations are served by members of the National Association of Mail Service Pharmacies (NAMSP).

You may ask why mail service? What do we provide that people cannot buy locally? To answer the question, we fill a definite need. AARP Pharmacy came into being as a direct consequence of disproportionately high medication expenditures, often for maintenance therapy, among AARP's members. Members from the outset were concerned primarily with two goals: 1) the most economical method of drug delivery, and 2) insistence on the best quality medications. In short, the AARP Pharmacy considers itself to be the medication buying agent for our members, not the selling agent for suppliers, performing a service on behalf of those members who need or want it.

Price consciousness is a common characteristic of mail service pharmacies--whether they serve members, beneficiaries, or the public. There are other reasons why our members choose to purchase from us--convenient delivery, AARP sponsorship, drug quality assurance, 100% credit, and service. Our members choose to have their prescriptions and other health care items filled by us because they may be disabled, infirm, live far away from a pharmacy or lack transportation to travel to a pharmacy.

We do not encourage our members to use us for all their prescription needs. In the case of medication for pain or infection which is required the same day, we urge members to purchase locally. However for maintenance drugs (such as for hypertension, diabetes, heart conditions) we can save members a lot of money--often more than found with a 10% senior citizen discount offered locally.

I think it's also important at this time to cite the key trends that have fueled and continue to fuel the growing popularity of the AARP Pharmacy Service and other mail-order pharmacies among American consumers:

First, there's been a tremendous explosion in the direct mail industry. People want to buy by mail. According to the direct marketing association, sales generated by direct mail have doubled since 1977 to account for $63.4 billion worth of business. Direct mail is an idea whose time has come and its effectiveness has been discovered by such well established companies as Avon, American Express and Tiffany's.

Second, is the growth of the generic drug industry. The AARP Pharmacy Service led the push for the sale of generic drugs more than twenty years ago. Today every state enables patients to purchase generic drugs.

And third, America is graying. AARP today serves 18 million Americans. The over-60 age bracket is the fastest growing segment of the U.S. population. This 11% of the population consumes over 30% of all prescription drugs.

These trends are reflected in the programs and services offered by the AARP Pharmacy Service.

First, we encourage our members to purchase generically. We heavily promote our generic brochure that compares prices on over 150 generic and trade name products.

Second, we are in various stages of implementing computerized patient profiles in all our pharmacies.

Third is our written prescription drug information program. We distribute leaflets called Medication Information Leaflets for Seniors (MILS). The MILS, prepared in conjunction with FDA and experts in geriatric medicine and pharmacy, tell in easy-to-understand language the various names of the medication, what conditions to take it for, how it should be taken, possible side effects, food and alcohol interactions, information that patients should tell their doctor before taking the drug, and warnings of possibly or probably effective ratings. These leaflets are geared to the specific medication needs of the elderly. One of the biggest concerns is that the print size be large with a lot of white space and clear graphics.

We began providing written drug information because 90% of the prescriptions we fill are delivered by mail or other delivery service. Having a reference binder or book available on a pharmacy counter is of very little benefit to many of the elderly who do not pick up their medicines in person.

As you all know, community pharmacists claim that pharmacist/patient consultation is a critical function they perform. In fact, one executive director of a state pharmaceutical association claims that only 51% of pharmacies provide consultation. You may therefore be interested in results of a recent national opinion telephone survey of 1001 Americans age 45 and over conducted by AARP.

While a bare majority of consumers regard their physicians as their chief source of general health information, nearly two-thirds turn to their doctor for information about prescription drugs, but to far fewer consumers--only 25% of the respondents.

Also, pharmacists are very inconsistent in providing vital information about prescribed drugs. For example, thirty-six percent of the respondents claimed their pharmacists always give the name of a drug, while 43% say they never do. Incidentally, AARP labeled prescriptions with the name of the drugs years before it was mandated. Similarly, 44% said they always are told the number of refills to get; 37% claim they never are told.

The largest majorities do not consistently receive information from pharmacists about side effects and adverse health reactions. Fifty-five percent stated they never are told the normal, predictable side effects of a drug. Even more, two-thirds (63%) never are warned of what to do if a severe reaction takes place.

Even though 17% of the respondents know that a book about drugs is available for public use at their pharmacy, a majority (55%) have no idea if such a resource exists at the drug store they patronize most frequently. Further, of those who are aware that such an information source is available, slightly less than one-third (30%) have ever used it.

When we started our MILS program three years ago, we distributed five leaflets. Today, after receiving favorable reactions from physicians and our members, we are now distributing 66 separate MILS, representing over 230 drugs. To date over 4.5 million MILS have been printed and nearly 4 million MILS have been sent to AARP members.

One of the major arguments leveled against mandatory patient package inserts (PPIS) was that these leaflets will scare people --people either won't read them, or if they do, they'll immediately stop taking their medication. We were interested in measuring patient acceptance of the leaflets, and in August 1982 performed an evaluation of the program with FDA to see what, if any, impact the leaflets had. We surveyed by mail 2,400 AARP members who had received one of their prescriptions from us. Seventy percent responded to our survey. The overwhelming majority gave the leaflets a strongly positive rating. Of those indicating they had received the leaflet, 95% said they read it; 76% said they kept it.

Most (69%) said the MILS provided them with information, and many (42%) said the MILS made them feel better about taking their medicine. The leaflets made only a small minority (2%) feel worse. This research is described in more detail in the February 1984 American Journal of Public Health.

This preliminary evaluation seems to warrant several conclusions - the MILS program is generally viewed in a positive manner by the elderly who receive the leaflets, and these leaflets might result in higher patient acceptance of their medicines, as well as potentially increasing utilization, thereby having a positive health impact.

Smith Kline & French awarded a grant to Dr. Jerry Avorn, Associate Professor, Harvard Medical School, to conduct a second evaluation of our leaflet program. This is the first large randomized controlled study of the impact of patient drug leaflets on the elderly. This evaluation will attempt to address such issues as:

- Impact of the MILS on the knowledge of recipients concerning safety and side effects
- Effects of MILS on attitudes about medications
- Effect of MILS on compliance.

As a fourth service of AARP Pharmacy, we were one of the first organizations in the country to offer on a national basis prescription braille labels on request to our visually impaired members. Fifth, we also provide a wide variety of home health supplies ranging from ostomy products to hearing aid batteries to wheel chairs to blood pressure kits.

AARP Pharmacy Service has been involved in working with and assisting medical schools on research projects concerning the elderly. For the past two years we have worked with Cornell Medical School on their three-year NIH grant to control hypertension in the elderly. The overall project goal is to measure the impact of the cost and ease of obtaining antihypertensives. The specific hypothesis of the study is there will be better control of blood pressure if drugs are provided free or at a minimum charge and are more readily available to patients over 65. Our role is to provide antihypertensive medications to the elderly in the New York area who are enrolled in the study.

In another project we are assisting Harvard Medical School in a study to analyze age, weight, and dose in drug prescribing for ambulatory elderly. The objective of this study is to determine how effectively physicians adjust drug dose for age and body weight. Data were obtained through a postcard survey enclosed with prescriptions for cimetidine, digoxin, and flurazepam filled by AARP Pharmacy.

In addition, the AARP Andrus Foundation awards competitive research grants in the field of aging. One such grant was awarded to the University of Maryland's Center on Aging to broaden the knowledge of pharmacists who serve the elderly in rural areas of the state. Since the local pharmacist is frequently the person whom the elderly consult about their health care needs, one objective of the AARP grant is to develop a training program that can be replicated in other rural areas.

At this point I'd like to spend a moment outlining the response and reaction of various government agencies--among them the Federal Trade Commission, Drug Enforcement Administration, and postal service--to allegations against mail order pharmacy.

A common charge leveled against mail order pharmacy concerns prescription fraud. In 1972, the Associate General Counsel for NARD wrote to then Senator Birch Bayh, "we are confident that any responsible investigation of mail-order practices by congress, Bureau of Narcotics and Dangerous Drugs, or any other group will demonstrate that widespread use of mails to deliver drugs subject to abuse contributes to the drug diversion and the nation's drug abuse problems...an outright prohibition on the mail-order sale and delivery of drugs subject to abuse is essential and long overdue."

Two months later, John Ingersoll, then director of the Bureau of Narcotics and Dangerous Drugs (BNDD), stated at the annual NARD meeting that one argument against mail-order pharmacy that concerned BNDD was the diversion of controlled substances. "...In response to similar allegations made in 1969, the Bureau conducted an investigation of mail-order pharmacies and concluded at that time: the findings do not lend credence to the suspicion that mail-order prescription firms are a major source of diversion for controlled drugs. On the contrary, the level of compliance with the drug abuse control amendments of 1965 compared reasonably well with the general run of prescription pharmacies."

What project script, as it was called, proved was that community pharmacies were more than twice as succeptible to fradulent prescriptions as mail service pharmacies.

Mr. Ingersoll stated "the Bureau is concerned with the relative ease that controlled substances are obtained from all pharmacies. But this problem is not confined to mail-order houses. Generally, it would appear that drug abusers are more likely to select a retail pharmacy rather than a mail-order pharmacy to attempt to pass a forged prescription. Their needs are of an immediate nature and more quickly satisfied through a fast purchase. Safety is also a factor. Abusers do not want to give a correct return address to a mail-order house and prefer doing business with a local pharmacy. The abuser can watch the pharmacist's reaction to a forged script and quickly leave if the pharmacist goes to the telephone..."

In 1975, the Federal Trade Commission examined documents pertaining to private mail order prescription pharmacies. FTC examined allegations made against mail-order pharmacies and then responded to them. Examples of report findings:

Allegation: Mail service pharmacy destroys bonafide physician/patient/pharmacist relationships.

Fact: "Mail order pharmacies utilize telephones for checking with physicians as much, if not more than retail pharmacists. Most mail order firms heavily utilize Wats lines for checking with physicians." Incidentally, the AARP Pharmacy Service spends hundreds of thousands of dollars in long distance telephone calls to provide oral consultation to physicians and patients about medications.

Allegation: Filling prescriptions by mail leads to drug diversion.

Fact: "Although forgeries might initially appear to be a potential problem, such possibilities have not been borne out by empirical studies and other evidence. By federal law, mail order retailers may not dispense narcotics, a class of controlled substances, through the mail. Thus, there is simply no possibility for mail order retailers to play a role in any problem concerning narcotics."

Project script, which I previously discussed, concluded that DEA officials believe retailers are more than twice as vulnerable to prescription forgeries than mail order pharmacies.

Allegation: Mail order prescription dispensing of drugs result in unwise delays in patient medication.

Fact: "FTC staff feels that allegations concerning delays in receiving medication through the mail are generally invalid and denigrate the common sense of American consumers. Staff informally surveyed governmental agencies and private interest groups likely to receive complaints concerning delays in medication. Officials from the post office; FDA's Office of Compliance, Bureau of Drugs; the White House Office of Consumer Affairs; and the Direct Mail Marketing Association stated the percentage of complaints received on this subject were negligible or too small to be measured.

According to officials from mail order pharmacies,

> consumers are not encouraged to send prescriptions for an acute illness by mail. Specific warnings in catalogs advise consumers to use local pharmacies for medication for acute pain or infections."

You may be surprised to learn that mailing controlled substances is regulated by the U.S. Postal Service and not by the DEA. Current postal regulations allow the mailing of schedules II - V non narcotic controlled substances. Pharmacists are not bound by quantity (or days supply) limitations for these non-narcotic products. Pharmacists cannot mail narcotic controlled substances to the ultimate user in any quantity. Only the Veterans Administration medical facilities are given authority to mail narcotics. When mailing any controlled substance, the parcel must be placed in a plain outer container or securely wrapped in plain paper and must not bear any markings indicating its contents.

Over the last year or so there have been an influx of state laws and regulations taking aim at mail order. I'll briefly review these as well as some relevant decisions from state attorneys general.

In Pennsylvania, the Pharmaceutical Assistance Contract to the Elderly (PACE) passed providing $100 million yearly to low and moderate income elderly. The PACE program enables Pennsylvanians over 65 with moderate incomes to purchase prescription drugs for $4.00. A regulation issued by the Pennsylvania Department of Aging, however, prohibits PACE claimants from filling their prescriptions by mail.

This regulation discriminates against the thousands of eligible older Pennsylvanians--in particular, the homebound, the handicapped and those who live in rural areas--who depend upon mail order delivery for pharmaceuticals and other health care items. They will have to do without the financial help that the PACE program would otherwise provide, because of the current restriction against mail-order pharmacies.

AARP and AARP Pharmacy is suing the commonwealth over this matter as well as actively supporting legislation to overturn this restriction.

A few years ago, the Iowa supreme court issued an important decision in Iowa vs. Rasmussen. The court held it unconstitutional and an unreasonable burden on interstate commerce for the state of Iowa to require that every physician in the U.S. become licensed in Iowa in order to treat Iowa citizens. The state of Iowa had attempted to prohibit an Iowa pharmacy from filling an out-of-state controlled substance.

Several states have either introduced legislation or regulations designed to require licensure and regulation of out-of-state mail service pharmacy operations. We oppose these efforts. AARP Pharmacy operated 10 pharmacies throughout the country and is licensed to operate in these states. We adhere to all federal and state laws and to the rules and regulations of the state boards of pharmacy in the states where we operate. Any requirement that a license be obtained in each of the fifty states raises substantial legal questions. Such a regulation or statute would constitute unreasonable burdens upon interstate commerce and would violate the commerce clause of the U.S. constitution.

Recently the Nebraska attorney general was asked his opinion on a pending bill requiring pharmacies operating outside Nebraska which mail prescriptions into the state to obtain a pharmacy license by the department of health. The attorney general concluded the bill was of suspect constitutional validity. He further stated that if this bill is considered as an attempt to protect pharmacies located within Nebraska from competing pharmacies located out-of-state, then the bill would be a form of economic protectionism invalid under the U.S. constitution.

The Wisconsin attorney general decided not to invoke a Wisconsin statute requiring out-of-state pharmacies to obtain a Wisconsin license. The deputy attorney general stated that his decision not to proceed against a Pennsylvania pharmacy was based on the absence of evidence that the pharmacy's mail order sales to Wisconsin Residents raised genuine health issues.

You are, of course, aware of the opinion of the attorney general of Ohio declaring it unconstitutional for states to require licensure in Ohio by any out-of-state pharmacy wishing to mail prescriptions into the state.

I'd like to suggest ways we might work cooperatively to solve some common problems. We recognize that consumers do not purchase all their prescription and OTCs at the same pharmacy all the time. Consumers shop around and buy at the grocery store and anywhere else they can. It behooves all of us to work together to get a handle on this situation. Perhaps we could have a universal carry around card. Everytime a consumer receives any prescription or OTC they should either write the name of the drug on the card or have the pharmacist enter it. We should wage an educational campaign to urge consumers to keep this card with them at all times.

In closing, it's foolhardy to attack mail-order pharmacies. The following trends in our business bear this out. First, mail order business...our business...will continue to grow at an accelerated pace. It's inevitable. People want convenience. They want the widest possible choice at the best price. And they want it without walking all over town to look for it.

Our particular business will grow because we are serving the fastest growing segment of the population. America is graying fast. By 1995, the over-60 population will be the largest single segment of the U.S. population. And although the older population is growing in affluence, they are still extremely price conscious. They want good prices because most of them are on fixed incomes.

This segment of the population also consumes more medicine than any other group...and they consume more maintenance type medications. They are also a fast growing market for vitamins and health products.

Mail-order pharmacies aren't going to put retail pharmacists out of business. Our portion of the overall market will remain very small even though we anticipate a lot of growth.

There are other economic forces at work that may have an adverse effect on retail pharmacists including movement of grocery chains, department stores and others into the drug and health business. Everybody is looking for a way to increase sales...and the pressure is on many businesses to increase sales. They see the growth in our business, so they add a pharmacy department.

Second, people have a right to know about the medicines they are taking. I spent a lot of time today talking about what we've done in terms of patient information. We are trendsetters in the business of giving the people the information they need. Nobody made us do it. We did it because it's the right thing to do. Not just because we're in the mail order business, but because people have a right to know...in intelligent, easy-to-understand terms what's likely to happen to them when they take a particular prescription medication.

You can't just plop a book on prescription drugs on a counter and think you've fulfilled your responsibility.

People are beginning to refuse to take certain medicines. And they're increasingly putting pressure on doctors not to fix every health problem with a "prescription fix." It's having a tremendous impact on the sale of certain drugs--or I should say the decline in sales--and I predict this trend will continue.

Third, insurance providers aren't going to sit still for higher and higher prescription costs. People in our field thought that some of the price pressure would be taken off when companies moved into providing prescription drug insurance. It has taken some of the consumer concern away, but the health insurers are increasingly concerned--and they're a much more dynamic force than individual consumers.

The same thing may happen in our field that is happening in hospitals and with doctors. For years, costs just kept going up and up. They skyrocketed. And nobody showed any particular concern because it was covered by insurance. Then, all of a sudden the insurers started saying, "Wait a minute. We're not paying all that money for people to lie around in hospitals." Now hospitals are facing empty beds because the average stay is less than three days.

Fourth, generic drugs will continue to grow in popularity and will become an increasingly dominant part of our business. Already generics account for more than 30% of all the prescriptions we dispense! That's why people have come to us by the millions. We pioneered the introduction of and public education about generics. It amuses me when I walk into a retail drug store now and see big signs that proclaim: "Ask me about generics." "Save up to 50% on generics." Drug stores act like they invented them! We've been giving that message for 20 years!

More education needs to be done. And the ones who help with that education--help save customers money--will win their loyalty. Retail pharmacy and mail order have coexisted for over a quarter of a century and there is no reason to believe that we cannot continue to enjoy friendly cooperation and fair competiion.

Mail service pharmacy is not for everyone--nor do we claim to be. We serve a need and we are not a threat to the community pharmacist doing his job and offering competitive prices. We believe american consumers want and deserve a diversity of pharmacies to serve their varied needs. And what they want is surely what they will get.

FEDERAL TRADE COMMISSION (FTC) STAFF REACTIONS TO ALLEGATIONS AGAINST MAIL SERVICE PHARMACY

Allegation: Mail Service Pharmacy Destroys Bonafide Physician/Patient/Pharmacist Relationships.

Fact: "Mail order pharmacies utilize telephones for checking with physicians as much, if not more than retail pharmacists. Most mail order firms heavily utilize WATS lines for checking with physicians." The AARP Pharmacy Service spends hundreds of thousands of dollars in long distance telephone calls to provide oral consultation to physicians and patients about medications.

Allegation: Mail Order Prescription Dispensing of Drugs Results in Unwise Delays in Patient Medication.

Fact: "FTC staff feels that allegations concerning delays in receiving medication through the mail are generally invalid and denigrate the common sense of American consumers. Staff informally surveyed governmental agencies and private interest groups likely to receive complaints concerning delays in medication. Officials from the Post Office; FDA's Office of Compliance, Bureau of Drugs; the White House Office of Consumer Affairs; and the Direct Mail Marketing Association stated the percentage of complaints received on this subject were negligible or too small to be measured.

According to officials from mail order pharmacies, consumers are not encouraged to send prescriptions for an acute illness by mail. Specific warnings in catalogs advise consumers to use local pharmacies for medications for acute pain or infection."

Allegation: Filling Prescriptions by Mail Leads to Drug Diversion.

Fact: "Although forgeries might initially appear to be a potential problem, such possibilities have not been borne out by empirical studies and other evidence.

First, by Federal law, mail order retailers may not dispense narcotics, a class of controlled substances, through the mail. Thus, there is simply no possibility for mail order retailers to play a role in any problem concerning narcotics.

Second, responding to considerable pressure exerted by the National Association of Retail Druggists, the Bureau of Narcotics and Dangerous Drugs, now Drug Enforcement Administration (D.E.A.), designed a study to compare mail order houses with that in retail, walk-in pharmacies. Results of "Project Script" showed retail store pharmacies were twice as likely to pass forged prescriptions for controlled substances as mail order prescription houses.

D.E.A. officials believe mail order pharmacies are less vulnerable to prescription forgeries because: (1) Forgers must take the chance of including their name and address on the forgery so that the prescription can be mailed to them. A prospective forger need not tender this information in a community pharmacy. (2) The forger can watch the retail pharmacist's reaction and escape from the store quickly if the pharmacist becomes suspicious. (3) Forgers of prescriptions don't wish to wait for drugs to be mailed. They typically want the drugs immediately. Apparently forgers would rather carry a forged prescription from store to store until it's filled than to take the chance of mailing it to a prescription pharmacy.

"Project Script" confirmed D.E.A.'s belief that mail order pharmacies are not a likely source for possible prescription forgery problems.

D.E.A. has inspected many of the mail order prescription firms and is satisfied that sufficient precautions are currently being taken to deter the likelihood of forgeries."

Allegation: Mail Order Prescription Drugs Can be Confusing to Patients Since Proper Verbal Counseling on a One-to-one Basis is Absent.

Fact: This response is from AARP Pharmacy Service, not FTC: For the past three years, AARP Pharmacy Service has been providing easy to understand drug information leaflets to its members. The Medication Information Leaflets for Seniors (MILS) are prepared with the assistance of the U.S. Food and Drug Administration and experts in geriatric medicine and pharmacy, and are geared to the specific medication needs of the elderly. Each MILS instructs the consumer on how to take the drug, provides important facts to remember, describes its uses and possible side effects, and explains what information the doctor needs to know when prescribing it. Fifty-nine leaflets are now available representing more than 80% of the medications we dispense. We are continually developing MILS for additional medications.

Additional charges leveled against mail service pharmacy includes:

Allegation: Mail order pharmacies cannot check for drug interactions since not all prescriptions or non-prescription products are acquired at the same outlet.

Fact: This is true. However, this is a problem whenever anyone shops at more than one pharmacy, a large chain grocery store, a mom and pop store, 7-11 store, etc. Studies show consumers do not consistently go to the same pharmacy so it is virtually impossible to monitor usage. When consumers purchase medications at many stores, the pharmacist will have only partial information regarding drug utilization on the profile.

Allegation: No mail order pharmacy can provide life sustaining medication within minutes after a physician orders it.

Fact: In the case of acute pain or infection, AARP Pharmacy urges members to purchase medications locally and not shop by mail.

STATISTICAL STUDIES AND SURVEYS ON MAIL-ORDER PHARMACY

PHARMACEUTICAL CARD SYSTEM, INC.

Actuarial Study of Mail Order Drug Option Experience

August 1, 1986
Richard B. Sieben, FSA, MAAA

SIEBEN & ASSOCIATES, INC.

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OVERVIEW

Continuing national focus on health care cost containment strategies has affected every segment of the delivery system. Strategic emphasis on outpatient alternatives to inpatient treatment has led to increased interest in the cost effectiveness of pharmaceutical therapies.

Existing outpatient pharmaceutical therapies are the preferred treatment for many medical conditions; and new therapies can enhance both the medical and cost effectiveness of the treatment of other conditions.

Recognition of the cost effectiveness of appropriate drug therapies has motivated health plan sponsors and participants to adopt plan design strategies improving participant access to such therapies.

Such strategies have led to the development of prescription drug benefit plans, featuring copayment schedules and coverage limitations and options appropriate to prescription drug expenses.

Drug benefit plan sponsors and underwriters have relied heavily on external prescription drug card networks for the development and administration of drug coverage.

Pharmaceutical Card System (PCS) has formed such a network, featuring direct provider reimbursement mechanisms. The substitution of provider reimbursement for participant reimbursement enhances access and reduces administrative cost levels below those achieveable in programs requiring submission of claims for reimbursement.

As an intermediary between drug plan sponsors and underwriters and the prescription drug dispensing system, PCS monitors the pricing practices of the dispensing system for cost containing opportunities.

Ingredient costs are the major component of prescription drug charges. PCS's primary cost containment contribution has been in establishing a national preferred provider network of community pharmacies, securing wholesale pricing for the ingredients dispensed to PCS cardholders.

Additional reductions in ingredient costs can be secured by increasing the relative usage of less expensive generic products for some drug therapies, and PCS has designed programs to secure increased generic substitution.

The second component of prescription drug charges is the pharmacists dispensing fee. In recent years, mail order pharmacies have developed highly efficient, computer-assisted, dispensing procedures. These savings in dispensing costs, together with reduced markups in ingredient costs resulting from the high volumes handled, have permitted mail order pharmacies to fill prescriptions at unit prices that are highly competitive with prevailing community pharmacy prices.

PCS has responded to plan sponsor interest in potential mail order cost savings by providing prescription drug programs featuring a Mail Order Drug Option (MDO). The number of PCS clients electing the option has increased steadily, and sufficient data has been accumulated to permit an actuarial study of the experience under such plans.

The primary objectives of the MDO actuarial study are to gather, analyze and report the experience of PCS clients with the MDO option and to determine the impact of the option on the cost of these programs.

Achieving these objectives required the assembly of a large amount of data to develop community pharmacy utilization and cost parameters that would serve as valid measurements of MDO experience. More data was used than it is reasonable to publish in securing the primary objectives of the MDO study. Therefore, the published MDO study will summarize findings wherever possible; and PCS will provide access to the "appendix" of raw data through the medium of floppy discs.

SUMMARY OF CONCLUSIONS

The study methodology involved developing a sample of claimant data from non-MDO PCS experience that closely matches the age, sex and employee/dependent mix characteristics of the MDO claimant data.

The claim data was broken down into categories based on the type of ingredients dispensed, and cost and utilization parameters were developed for each drug class.

Tests were applied to establish that these drug class parameters were consistent between claimant populations, and they were applied to MDO group patient and volume counts for each drug class to project expected community pharmacy charge levels for the MDO group.

The result of these calculations is that the MDO groups actual charges exceeded the expected charges by 5%. Although the MDO groups did experience lower unit costs of 4%, these unit savings were wiped out by increased volumes of ingredients and days of fill of slightly over 9%.

Total charges for prescriptions filled at mail order pharmacies represented 8.1% of total MDO charges. For individual drug classes, mail order charges varied from 0% to 60% of the class total.

The data for the several drug classes was analyzed by relative mail order pharmacy usage, and a strong correlation was identified between the extent of mail order usage and the degree of excess actual to expected MDO charges: the greater the mail order usage, the greater the excess volumes dispensed and the greater the excess cost.

Tables 1-4 document these findings. Tables 5A and 5B present the cost comparisons for a prescription drug card plan, introducing administrative handling charges and deductibles into the analysis. The excess MDO group cost varies from 4.9% to 7.7%, depending on the blend of assumptions and deductible levels.

These tables relate the excess costs to the separate costs for prescriptions filled at mail order pharmacies and show that they represent from 56% to 70% of those costs, implying that it is unlikely that further reductions in mail order pharmacy unit costs can overcome the increased volumes of ingredients dispensed to mail order patients.

The majority of the MDO groups included in the experience study had 180 day mail order fill limits, while a smaller number had 90 day fill limits. Comparison of two subsets of MDO claimant data showed that the group with relatively more 90 day fill limits had experience better than the average, although it still had excess charges of 2.8% over expected levels.

A separate analysis was made to estimate the impact of a 90 day fill limit for all MDO groups: the estimated reduction in total charges was 2.2%, and the excess over expected charges was reduced to 2.7% from 5%.

While the unit cost savings in mail order fills are significant, they are more than eliminated by the increased volumes dispensed. These increased volumes represent an acceleration of plan sponsor costs, since there is a prepurchase of future monthly refills; and they increase exposure to the cost of spillage, or wastage, that results from either patient non-compliance with the therapy or physician modification of the treatment.

The study is based on experience for a one year period beginning April 1, 1984. As mail order pharmacy pricing appears to have become more aggressive, and plans with 90 day limits have become more prevalent, the current excess cost differential is likely to be somewhat lower than that calculated in the study. It is, however, highly unlikely to disappear; and the only cost savings generated by MDO plans are those that accrue to plan participants from the reduction in out of pocket expenses for multiple refill deductibles.

MDO GROUP SELECTION

As of January, 1984, PCS MDO plans covered approximately 225,000 adult cardholders and spouses.

Incurred claim experience was gathered for these plans for the twelve month period commencing April 1, 1984, and ending March 31, 1985.

Groups whose relative utilization of mail order facilities was nominal were excluded from the study. Dependent children claims were also excluded because of low mail order usage.

The study was restricted to those groups whose MDO option was in effect prior to January 1, 1984. Over 60% of the claims paid during the study year came from groups whose MDO option took effect prior to January 1, 1983. This precluded comparisons of experience before and after election of the MDO option.

CLAIMANT DATA

PCS maintains an extensive data base containing detailed claim and claimant information for every prescription reimbursed.

Claimant demographic data identifying the claimant and the claimants age, sex and employee or dependent status are maintained on each claim record. This data was summarized for the MDO group, two sample groups and for all 1985 PCS claims.

Exhibit 1 summarizes the claimant demographic characteristics of these populations. The averages and percentages shown are calculated by using the amount of prescription charges: they are claim dollar weighted averages.

Comparison of the distribution of MDO group claims with aggregate PCS experience suggests that it would be inappropriate to use aggregate PCS claimant cost and utilization parameters for projecting expected MDO group claimant costs.

The MDO groups had significantly more claims for claimants over age 65, a higher claim weighted age distribution for persons under age 65, and a relative claim distribution by sex and between cardholders and spouses that differed from aggregate PCS experience.

The MDO groups have more extensive retiree coverage and older active employee populations. As utilization of prescription drug plans increases steadily with age, expected claim parameters derived from aggregate PCS experience might understate expected cost levels.

CONTROL GROUP SELECTION

The task, then, was to construct a sample of non-MDO PCS experience that would serve as a valid measure of expected community pharmacy costs for comparing actual MDO group costs.

A control group (CG1) was constructed from a subset of 31 of PCS's 100 largest clients. The control group participants were selected prior to the compilation of detailed claimant data, with the objective of matching the MDO groups claim distribution by age, sex and employee/spouse mix.

It was not possible to secure the desired match for the entire MDO group population because of the high proportion of claims incurred by persons over age 65. Therefore, claimant experience was compared separately for persons under and over age 65, and the matching criteria were applied independently for both age groups. The close match between the MDO groups and the primary control group (CG1) is apparent in Exhibit 1, particularly for the over 65 population.

A second control group (CG2), or validation group, was constructed from the 69 clients not included in the primary control group. The under age 65 claimants are younger than the MDO and CG1 claimants, and the female content and cardholder/ spouse mix deviate at all ages.

The over age 65 claim volume was considerably thinner for the second control group as a result of including those clients with the heaviest retiree exposure in the primary control group to achieve the objective of matching the MDO groups claim distribution. This limited the utility of the second control group for validating over 65 claimant parameters.

The reason for seeking a control group matching the claimant profile of the MDO groups is that PCS's eligibility records for cardholders and dependents do not contain the demographic data obtained at the time the prescription is filled.

The absence of detailed demographic data on eligible participants is a common problem in developing utilization and cost parameters for comparing experience under group health plans covering different populations. The solution is to secure a demographically matched claimant sample and to use claimant parameters for comparing experience.

CLAIMANT PARAMETERS BY USC CLASS

The detailed PCS claim records facilitate the derivation of extensive cost and utilization parameters for claimants. For each prescription, PCS records identify the dispensing pharmacy, the type of ingredients, the ingredient cost, the dispensing fee, the number of units of ingredients, and the number of days of fill.

PCS encodes all claims using the Uniform System of Classification (USC) codes. The claim data included in the MDO study was compiled by USC class. For each USC class, PCS summarized the number of claims (prescriptions), dollars of ingredient costs and dispensing fees (total charges), the quantity (units) of ingredients dispensed, the number of days of fill and the number of patients.

A patient is defined as one person having one or more prescriptions for drugs in a specific USC class during the study year.

Exhibit 2 lists the 96 USC classes included in the study by USC code. Claim activity was reported for over 200 such classes. Many USC classes contain only one drug. Others consist of a family of similar drugs. Some drugs have a single therapeutic use, while others have multiple uses.

Exhibit 2 can be used to identify USC codes used in the exhibits following. The rank by total charges is shown for each USC class for each of the four major experience study groups. Antiarthritics (USC 91) had the highest total charges for all groups and shows a rank of 1. An "x" in the rank column means that claims from that USC class were not included in the experience study group sample.

The distribution of charges is highly concentrated by USC class, with 22 USC classes accounting for 80% of total charges. The MDO study was based on 96 USC classes. This subset of 96 USC classes includes the top 75 USC classes ranked by charges for all of the study groups included in the MDO study. The experience of each study group includes the claims of 80 or more USC classes, accounting for 99% of total charges.

Claims for oral contraceptives were eliminated entirely from the study: coverage is offered on an optional basis, and the option election rate varied widely between the populations studied.

The key premise of the MDO claim study is that large populations of patients coming from closely matched groups will display similar utilization characteristics for a specific USC category.

Through observing and comparing patient utilization and cost parameters within USC classes, we should find consistency between populations at the USC level; and the observed differences in aggregate severity and utilization curves by age and sex can be accounted for by changes in the mix and frequency of therapies.

Although the incidence of patients requiring a specific drug therapy may vary by age and sex, the critical assumption is that parameters such as days per patient, units per day, or cost per unit should be substantially the same within a specific USC class.

Exhibit 3 summarizes claim data for the MDO group, the two control groups and for the MDO client subgroup whose options were effective on or before January 1, 1983. The claim samples include a sufficient number of prescriptions and patients to make an experience analysis.

For the MDO group, data by USC class was compiled separately for mail order and community pharmacies as well as on the combined basis shown in Exhibit 3. The patient totals by pharmacy type exceed the combined total, since individuals could have had both types of fill for the same USC class. Such individuals were counted as one patient in the combined data summary and in each of the summaries by pharmacy type.

CONTROL GROUP PARAMETER VALIDATION

Two tests were applied to determine the reasonableness of the assumption that USC claimant parameters are consistent between similar populations.

The under 65 USC cost parameters for the primary control group (CG1) were used to project expected claim costs for the second under 65 control (validation) group (CG2). The results by parameter were as follows:

Projection Parameter	Actual to Expected Ratio
Cost Per Claim	100.23%
Cost Per Unit	100.25%
Cost Per Day	99.78%
Cost Per Patient	99.91%

Exhibit 1 shows that the demographic profile of CG1 is more closely matched to the MDO groups profile than it is to the CG2 profile. Therefore, CG1 claimant cost parameters appear to be reasonable standards for determining expected MDO group retail pharmacy costs.

The second test was to project over 65 costs from under 65 USC claimant cost parameters for CG1 and for the MDO groups. The results by parameter were as follows:

Projection Parameter	Actual to Expected Ratio	
	CG1	MDO Group
Cost Per Claim	101.6%	102.9%
Cost Per Unit	95.8%	95.1%
Cost Per Day	94.1%	94.0%
Cost Per Patient	118.0%	117.5%

The differences by parameter reflect the changes in the mix of patients and treatment frequency for two populations with widely different ages. The important outcome is the proximity of the actual to expected ratios for each parameter between CG1 and the MDO group. The impact of an increase in claim weighted age of approximately 24 years is nearly identical for the two groups, again suggesting that claimant parameters derived by USC class are appropriate predictors of expected costs for closely matched groups.

The high actual to expected ratios for the cost per patient parameter reflect an increase in the number of claims per patient in the over 65 population. Although greater intensity of care should be expected for the elderly, lower turnover rates will also apply to a retired population. The average months of coverage per patient will be higher than for an under age 65 population. This would also increase the claims per patient ratio.

CONTROL GROUP PARAMETER DEVELOPMENT

Exhibits 4 and 5 display the CG1 claim data by USC code for the under and over 65 populations, respectively. The data is ranked by the amount of USC class charges in descending order. The final two columns show the relative and cumulative percentage of total charges. The bottom row (900) shows sample percentages relative to total charges for all USC classes.

Exhibit 6 and 7 display the CG1 claim parameters for the under and over 65 populations, respectively. These parameters are derived from Exhibits 4 and 5 and are ranked in the same order.

Comparison of the claim parameters of Exhibits 6 and 7 implies an increased intensity of care for the over 65 population. Within each USC class, the claims per patient parameters of Exhibit 7 are consistently higher than those of Exhibit 6, which is the primary cause for the increased cost per patient parameters.

Expected costs projected using costs per unit and costs per day will identify variations in unit pricing between populations. Longer fills reduce the daily cost of the dispensing fee element of the prescription charges. Although increased intensity of care may lower unit or daily costs, the costs per claim and per patient will increase. Costs per patient incorporate all of the utilization and pricing elements that determine plan claim costs.

Actual to expected charges ratios based on projections of expected charges per patient are the critical test for comparing claim costs between populations. Charges per unit and per day vary inversely with the amount of ingredients dispensed per prescription, as will actual to expected charges ratios projected from these parameters. The projections of over age 65 charges illustrates this point clearly: the cost per patient actual to expected ratios accurately reflect the higher costs of this population, while the per unit and per day ratios are less than 100% because of the increased intensity of medication.

The claim cost parameters of Exhibits 6 and 7 were applied to the claim data of the corresponding experience study groups in performing the validation tests described at the beginning of this section. They were also applied to the MDO groups to calculate expected claim costs.

MDO CLAIM COSTS

Exhibits 8 and 9 display the MDO claim data for the under and over 65 populations, respectively. This data is ranked by total USC class charges. The data of the first five columns is for all pharmacies: community and mail order. The last two columns show the subtotal of mail order pharmacy charges and the percent of the USC class charges occuring at mail order pharmacies.

Expected charges for under 65 MDO USC classes are derived by multiplying the cost per unit, per day and per patient parameters from Exhibit 6 by the corresponding unit, days and patient counts in Exhibit 8. The parameters of Exhibit 7 are applied to the counts of Exhibit 9 to derive expected charges for the over 65 population.

The expected charges represent community pharmacy costs, since the parameters of CG1 reflect community costs. Expected MDO group charges can not be derived by applying community cost per claim factors to MDO group claim counts. The MDO claim counts include the mail order pharmacy claims, which may be for as much as 180 days of fill, compared to typical community pharmacy fill limits of 30 days. Application of community cost per claim parameters would understate expected community costs and produce misleadingly inflated actual to expected charge ratios.

The following example illustrates the calculation of expected community charges for systemic antiarthritics (USC class 91) for the under age 65 population:

(Exhibit 8)	Units	3,554,865
(Exhibit 6)	Cost per Unit	x 0.47
	Expected Charges	$1,670,787
(Exhibit 8)	Days	1,469,692
(Exhibit 6)	Cost per Day	x 1.14
	Expected Charges	$1,675,449
(Exhibit 8)	Patients	25,116
(Exhibit 6)	Cost per Patient	x 59.40
	Expected Charges	$1,491,890

The actual charges for the MDO group for USC class 91 are shown in Exhibit 8 as $1,626,742. The ratio to expected patient charges is 109%. Mail order pharmacy charges for this class were $164,951, the second highest amount of any USC class, equal to 10.1% of total charges. Clearly, systemic antiarthritics are used as maintenance therapies; and the 180 day mail order fill allowances make exercise of the mail order option attractive to patients on maintenance therapies.

Actual to expected charge ratios by unit and by day are 97%, reflecting the savings in the actual drugs dispensed. Actual MDO charges for those USC classes with active mail order pharmacy usage will be lower than expected community pharmacy charges calculated on the basis of units and days.

Claim data were separately compiled for mail order pharmacy prescription fills as in Exhibits 8 and 9. The following table summarizes the results of applying the CG1 factors to the mail order pharmacy claim data:

Expected Charges Projection Method	Actual to Expected Ratio Under 65	Over 65
Cost per Unit	80.8%	84.0%
Cost per Day	71.6%	74.2%
Cost per Patient	157.5%	134.5%

Mail order pharmacy costs per unit and per day are lower, as expected. The high actual to expected ratio derived from costs per patient is a result of the much larger prescription fills permitted at the mail order pharmacies. Most patients don't exercise their mail order option for small fills.

ACTUAL TO EXPECTED MDO CHARGES

The calculations described above were applied to each MDO USC class to generate expected community pharmacy charges for the over and under age 65 study groups. Tables 1 and 2 summarize the results of these calculations.

Both tables are ranked by ascending relative mail order usage. These are the ratios shown in the last column of Exhibits 8 and 9. They are displayed in column 3 of Tables 1 and 2.

Expected retail charges are displayed on a cumulative basis for each of the three projection methods in columns 4 through 6.

Column 7 represents cumulative actual MDO group charges. Column 8 shows the ratio of the cumulative actual charges (column 7) to total actual charges (row 998 of column 7).

Column 9 shows cumulative actual mail order pharmacy charges, and column 10 shows the ratio of column 9 to cumulative total MDO group charges (column 7).

Column 11 shows the ratio of column 9 to total mail order pharmacy charges (row 998).

Columns 12 through 14 show the ratio of actual charges to expected community pharmacy charges by projection parameter. These ratios are calculated by dividing column 7 by columns 4, 5 and 6, respectively.

Columns 12 and 13 reflect the reduced unit and days fill costs realized by the blend of community and mail order prescriptions. However, patients are the constant factor, and the ratios of column 14 represent the actual cost differentials.

Columns 15 and 16 are calculated by dividing column 14 by columns 12 and 13, respectively. The ratios of these columns represent measurements of the additional units and days of fill supplied to the MDO groups.

CORRELATION BETWEEN MAIL ORDER USAGE AND EXCESS COST

Table 3 extracts the highlights from Tables 1 and 2, repeating columns 8, 10 and 14 from those Tables.

Comparison of columns 8 shows that charges are much more highly concentrated in a relatively small number of USC categories for the elderly. The elderly also use the mail order option more heavily at all points in the range, as examination of columns 10 shows.

The major outcome is in the patterns in column 14: the cumulative actual to expected patient charges increase as mail order usage increases.

For the under 65 population, actual charges remain very close to expected community costs through the first 28 USC classes, which represent 21.4% of total charges and have a mail order charge ratio of 1.0%. This outcome further demonstrates the validity of the assumption that USC claimant parameters are consistent measurements of community pharmacy utilization and cost: with minimal mail order usage, these 28 USC classes had actual charges equal to expected community charges.

For the over 65 population, the actual to expected ratio hovers between 102% and 103% until the relative mail order usage exceeds 5%.

Table 4 displays the correlation between cost and mail order pharmacy usage clearly. The data of Tables 1 and 2 are segmented into four quartiles, based on the distribution of total charges (column 6). As mail order pharmacy usage (column 8) increases from quartile to quartile, the actual charges relative to retail charges (column 12) increase.

The over 65 population has higher mail order usage (9.2% vs. 7.6%) and displays higher actual to expected charges (106.1% vs. 104.6%). For the total MDO client group, mail order usage is 8.1%, and charges exceed expected community charges by 5%.

The savings on a per unit and per day of fill basis are approximately 4% (columns 10 and 11). Thus, the MDO groups had slightly over 9% more drugs dispensed, as shown in columns 13 and 14 of Table 4.

The correlation between mail order usage ratios and excess charges is apparent: the greater the relative mail order usage, the greater the volumes dispensed and the greater the excess of charges over community pharmacy levels. More drugs are ordered and dispensed when access to mail order pharmacies is available; and the additional volumes dispensed overcome the unit savings delivered.

MDO DRUG BENEFIT PLAN COSTS

Thus far, all of the cost comparisons have been based on charges. Insured drug programs apply copayments and administrative handling fees on a per prescription basis. This following section will develop the expected community vs. MDO cost comparisons on that basis.

Table 5A derives claim and handling costs for the under and over 65 populations using the actual and expected MDO group charges derived in the prior section. The second line of the calculation shows prescription counts. As noted in the footnote to Table 5A, the expected number of prescriptions is calculated by applying the USC class claims per patient parameters of Exhibits 6 and 7 to the patient counts of Exhibits 8 and 9.

Table 5B uses an alternate method of projecting the number of expected prescriptions: mail order claims were adjusted to reflect community pharmacy fill limits to determine the number of claims the MDO groups would have had on a community basis, and the adjusted claims were reduced proportionately to the expected charges levels.

The actual to expected ratios are shown at each step in the calculations, and the impact of the two methods of projecting the number of prescriptions is apparent: actual MDO group prescription counts are greater than expected in Table 5A and lower in Table 5B.

The next step in the calculation is the application of the average PCS handling fee prevalent during the study year ($0.67 per claim). The cost for a plan without a deductible equals charges plus administrative cost.

The cost for the several deductible levels is calculated by subtracting the product of the deductible and the prescription count from the cost of a plan with no deductible. Under both assumptions, the actual to expected ratios decline moderately from the ratios calculated for charges to the ratios for a plan with no deductible. The ratios increase as the deductible increases, and the rate of increase is more severe in Table 5B.

The excess of actual cost over expected cost is shown at each step in the calculations. The excess MDO group cost decreases as the deductible increases in Table 5A, since the actual number of prescriptions exceeds the expected number. The deductible savings have greater impact on expected claims under the assumptions of Table 5B, and the excess cost increases as the deductible amount increases.

The same calculations are applied to the prescriptions dispensed by mail order pharmacies. Each dollar of deductible reduces mail order costs by approximately 2%, while the reduction in total MDO group costs is 6.2% per dollar of deductible.

The final column shows the ratio of the excess MDO group costs to the mail order pharmacy costs. These ratios imply that mail order unit prices would have to be reduced by more than 55% from the levels prevailing during the study year to compensate for the cost impact of the additional units and days of fill supplied.

MDO EXPERIENCE BY OPTION YEAR

The MDO study group excluded clients whose MDO option was effective after January 1, 1984. Over 60% of the study year claims were from clients whose option was effective prior to 1983. Conversely, a significant portion of the charges were incurred by programs in their start-up year, and it is worthwhile to examine the two subgroups separately to determine whether initial mail order fills have a distorting influence.

The MDO groups claim data was separately compiled for groups whose option was effective prior to or after January 1, 1983.For the pre-1983 programs, data was also compiled for the year prior to the study year: April 1, 1983 through March 31, 1984. The inflation rate for the several cost parameters was calculated for this group between years and was applied to the 1983-1984 experience to permit consistent comparison with 1984-1985 expected claim costs.

The critical ratios for these populations are displayed in Table 6. The newer groups (1983 option dates) were heavier relative users of mail order pharmacies, but showed lower excess charges by patient ratios. The older groups (pre-1983 option dates) showed higher excess cost ratios, and the ratios were consistent for both experience periods. The inclusion of programs recently electing the MDO certainly didn't adversely effect the actual to expected ratios.

MDO LENGTH OF FILL

Most of the plans initially electing an MDO option contained a 180 day mail order pharmacy fill limit. A 90 day fill limit is also offered and has been elected with increasing frequency. 87.7% of the pre-1983 groups claims were from plans with the 180 day limit, while only 67.7% of the 1983 groups claims were from such plans. The reduced exposure to the higher fill limit probably accounts for part of the difference in actual to expected cost ratios between the two groups.

The higher limit may well be a contributing cause of the excess utilization of the MDO groups. There is certainly a spillage, or wastage, factor in prescription drugs: patient non-compliance or physician modification of the treatment will result in unused drugs. The likelihood of increased spillage certainly increases with longer fills.

In addition, it should be recognized that prescription drugs represent the pre-purchase of medical treatment, quite unlike other items of health care. The traditional community pharmacy fill limits are consistent with normal group health plan restrictions of reimbursement to those services and treatments provided in the current month of coverage.

The extension of fill limits beyond 30 days puts the plan sponsor at risk that the therapy will continue to be medically appropriate, that the patient will comply with the therapy and that the patient will remain an eligible health plan participant.

The extent of this overpurchasing risk is ignored in cost comparisons focusing only on comparable community unit costs. The cost parameters of the study were applied to the mail order pharmacy claims to determine what the same quantity of drugs would have cost had they been ordered at community pharmacies. The mail order savings in charges and in costs for a drug plan with a $3.00 deductible were as follows:

	Charges	$3.00 Deductible
Under Age 65	26.2%	19.5%
Over Age 65	24.6%	18.1%
All Ages	25.7%	19.0%

Clearly these savings in the cost of the prescriptions were wiped out by the additional ingredients dispensed. Under the community 30 day fill and refill limits, there is some likelihood that less than 6 prescriptions would, in fact, be filled in place of a mail order 180 day fill.

In addition, some of the fills would have occurred beyond the end of the study year: the longer fills represent inventory; and the cost is current, rather than deferred.

While a 90 day mail order fill limit would not substantially reduce the relative mail order savings over the cost of obtaining the equivalent quantity of drugs at a community pharmacy, it would certainly reduce the plan sponsors exposure to some of the spillage and pre-fill risks identified above.

A rough measurement of the potential impact of a 90 day fill limit on the MDO groups costs was made by analyzing the USC days of fill per claim parameters for the mail order claims. If, for example, the average fill per claim was 120 days for a USC class, 25% of the total charges were eliminated: the cost of the excess fill over 90 days was thrown out entirely.

This reduced the average fill for all mail order USC classes from 124.3 days per claim to 88.6 days per claim. Total charges decreased by $550,000, or 27.1% of mail order charges. This represents a 2.2% reduction in total MDO group charges, and would reduce the actual to expected charges ratio developed in Table 4 from 105% to 102.7%

PARTICIPANT COSTS

All of the cost comparisons thus far have been from the perspective of the plan sponsor. As most prescription drug programs require copayments per prescription, it should be noted that some savings do accrue to patients using the mail order option when the mail order deductibles are the same as the deductibles applied at the community pharmacies.

In the preceding section, reference was made to an analysis of what the community pharmacy costs would have been had the mail order volumes been filled subject to the community pharmacy fill limits. If all of the ingredients were, in fact, dispensed, there would have been 106,321 additional prescriptions. Thus, mail order claimants would have paid $318,963 less in deductibles if the average deductible is $3.00.

The following table summarizes the participant deductible savings relative to the plan sponsors excess cost by deductible as shown in Tables 5A and 5B:

Deductible	Participant Savings/Excess MDO Cost	
	Table 5A	Table 5B
$1.00	8.8%	9.0%
$2.00	17.2%	18.5%
$3.00	25.3%	28.7%
$4.00	33.1%	39.6%
$5.00	40.6%	51.4%

These calculations again assume that all of the refills necessary to match the mail order volumes would have been dispensed. While participants realized some savings, the savings were not sufficient to compensate for the excess costs incurred by the plan sponsors.

TABLE 1: NDO UNDER 65 EXPERIENCE SUMMARY

(1) USC CODE	(2) CLASSIFICATION NAME	(3) % MAIL ORDER BY USC	(4) [CUMULATIVE EXPECTED CHARGES] BY UNITS	(5) BY DAYS	(6) BY PATIENTS	(7) CUMULATIVE CHARGES	(8) PERCENT OF ALL CHARGES	(9) CUMULATIVE MAIL ORDER CHARGES	(10) PERCENT MAIL ORDER	(11) % OF ALL MAIL ORDER	(12) [CUMULATIVE ACTUAL TO EXPECTED] BY UNITS	(13) BY DAYS	(14) BY PATIENTS	(15) UNITS PER PATIENT	(16) DAYS PER PATIENT
782	Scabicides & pediculocides	0.00%	12,572	11,081	12,519	12,045	0.1%	0	0.0%	0.0%	95.8%	108.7%	96.2%	100.4%	88.5%
344	Preps-cough only	0.08%	113,636	101,956	113,026	108,099	0.6%	76	0.1%	0.0%	95.1%	106.0%	95.6%	100.5%	90.2%
181	Anti-obesity, Schedule II	0.28%	130,066	116,535	125,328	122,016	0.7%	115	0.1%	0.0%	93.8%	104.7%	97.4%	103.8%	95.0%
152	Penicillins	0.31%	280,306	266,789	270,833	261,322	1.5%	544	0.2%	0.0%	93.2%	98.0%	96.5%	103.5%	98.5%
616	Ophth: Anti-infectives	0.32%	319,443	300,064	308,642	298,353	1.7%	661	0.2%	0.0%	93.4%	99.4%	96.7%	103.5%	97.2%
690	Proprietary Smoking Deterent	0.32%	455,105	432,341	443,407	432,255	2.4%	1,094	0.3%	0.1%	95.0%	100.0%	97.5%	102.6%	97.5%
182	Anti-obesity, other preps.	0.43%	590,733	560,183	563,367	560,032	3.1%	1,638	0.3%	0.1%	94.8%	100.0%	99.4%	104.9%	99.4%
151	Antibiotics, broad & medium	0.43%	2,055,771	2,006,315	1,950,095	1,959,666	11.0%	7,627	0.4%	0.6%	95.3%	97.7%	100.5%	105.4%	102.9%
22	Analgesics, narcotic	0.55%	2,467,521	2,401,163	2,319,988	2,340,382	13.1%	9,726	0.4%	0.7%	94.8%	97.5%	100.9%	106.4%	103.5%
343	Cough/cold preparations	0.61%	2,588,962	2,523,746	2,440,535	2,460,260	13.8%	10,461	0.4%	0.8%	95.0%	97.5%	100.8%	106.1%	103.4%
372	Anti-infectives, topical	0.74%	2,602,041	2,535,675	2,453,887	2,473,257	13.9%	10,557	0.4%	0.8%	95.1%	97.5%	100.8%	106.0%	103.3%
602	Supplements: Fluorides	0.93%	2,609,968	2,545,455	2,462,217	2,480,818	13.9%	10,627	0.4%	0.8%	95.1%	97.5%	100.8%	106.0%	103.4%
523	Corticoids in combinations	0.95%	2,754,932	2,681,708	2,611,674	2,624,414	14.7%	11,994	0.5%	0.9%	95.3%	97.9%	100.5%	105.5%	102.7%
492	Hemorrhoidal preps. w/cort.	1.06%	2,809,369	2,732,799	2,663,688	2,675,729	15.0%	12,538	0.5%	0.9%	95.2%	97.9%	100.5%	105.5%	102.6%
376	Anti-dandruff preparations	1.39%	2,822,027	2,744,022	2,676,200	2,687,602	15.1%	12,703	0.5%	0.9%	95.2%	97.9%	100.4%	105.4%	102.5%
371	Acne therapy	1.40%	2,867,006	2,785,834	2,718,096	2,729,038	15.3%	13,284	0.5%	1.0%	95.2%	98.0%	100.4%	105.5%	102.5%
155	Trimethoprim	1.55%	3,020,361	2,929,607	2,847,826	2,861,258	16.1%	15,338	0.5%	1.1%	94.7%	97.7%	100.5%	106.1%	102.9%
788	All other misc. ethical drugs	1.62%	3,097,202	3,011,141	2,936,168	2,938,410	16.5%	16,591	0.6%	1.2%	94.9%	97.6%	100.1%	105.5%	102.6%
12	Trichomonacides	1.65%	3,159,306	3,075,599	2,997,498	3,000,040	16.9%	17,610	0.6%	1.3%	95.0%	97.5%	100.1%	105.4%	102.6%
761	Multivitamins	1.75%	3,253,480	3,170,214	3,090,975	3,091,779	17.4%	19,215	0.6%	1.4%	95.0%	97.5%	100.0%	105.3%	102.6%
374	Fungicides	1.96%	3,529,553	3,448,016	3,361,533	3,360,894	18.9%	24,488	0.7%	1.8%	95.2%	97.5%	100.0%	105.0%	102.6%
672	Non-barbiturate sedatives	2.43%	3,654,056	3,575,899	3,477,371	3,484,708	19.6%	27,502	0.8%	2.0%	95.4%	97.4%	100.2%	105.1%	102.8%
170	Antinauseants	2.59%	3,747,874	3,665,841	3,556,908	3,567,472	20.0%	29,644	0.8%	2.2%	95.2%	97.3%	100.3%	105.4%	103.1%
141	Antihistamines, caps & tabs	2.63%	3,837,408	3,753,913	3,647,006	3,648,608	20.5%	31,776	0.9%	2.4%	95.1%	97.2%	100.0%	105.2%	102.9%
378	Dermatologicals, Other	2.64%	3,845,488	3,761,307	3,655,178	3,655,957	20.5%	31,970	0.9%	2.4%	95.1%	97.2%	100.0%	105.2%	102.9%
235	Urinary tract antispasmodics	2.84%	3,857,447	3,773,093	3,665,343	3,667,067	20.6%	32,285	0.9%	2.4%	95.1%	97.2%	100.0%	105.2%	102.9%
231	Antispasm., synthetic	2.96%	3,906,965	3,823,439	3,713,731	3,715,436	20.9%	33,716	0.9%	2.5%	95.1%	97.2%	100.0%	105.2%	103.0
154	Urinary antibacterials	3.03%	4,006,907	3,922,337	3,802,505	3,807,050	21.4%	36,495	1.0%	2.7%	95.0%	97.1%	100.1%	105.4%	[illegible]
641	Tranquilizers	3.13%	5,215,293	5,131,502	4,892,756	4,969,782	27.9%	72,896	1.5%	5.4%	95.3%	96.8%	101.6%	106.6%	[illegible]
21	Analgesics, non-narcotic	3.33%	5,801,776	5,690,733	5,401,802	5,529,413	31.1%	91,547	1.7%	6.8%	95.3%	97.2%	102.4%	107.4%	[illegible]
373	Antipruritics	3.39%	5,819,078	5,705,659	5,417,728	5,545,024	31.1%	92,076	1.7%	6.8%	95.3%	97.2%	102.3%	107.4%	[illegible]

TABLE 1: MDO UNDER 65 EXPERIENCE SUMMARY

(1) USC CODE	(2) CLASSIFICATION NAME	(3) % MAIL ORDER BY USC	(4) [CUMULATIVE EXPECTED CHARGES] BY UNITS	(5) BY DAYS	(6) BY PATIENTS	(7) CUMULATIVE CHARGES	(8) PERCENT OF ALL CHARGES	(9) CUMULATIVE MAIL ORDER CHARGES	(10) PERCENT MAIL ORDER	(11) % OF ALL MAIL ORDER	(12) [CUMULATIVE ACTUAL TO EXPECTED] BY UNITS	(13) BY DAYS	(14) BY PATIENTS	(15) UNITS PER PATIENT	(16) DAYS PER PATIENT
591	Muscle relaxants, non-surgical	3.50%	6,152,840	6,031,491	5,725,441	5,860,944	32.9%	103,124	1.8%	7.7%	95.3%	97.2%	102.4%	107.5%	105.5
522	Corticoids, plain	3.71%	6,745,501	6,631,099	6,288,779	6,421,905	36.1%	123,952	1.9%	9.2%	95.2%	96.8%	102.1%	107.3%	105.4
301	Anti-Leukemia Drugs	3.81%	6,771,515	6,658,647	6,309,209	6,439,469	36.2%	124,622	1.9%	9.2%	95.1%	96.7%	102.1%	107.3%	105.5
341	Oral cold preparations	3.84%	7,196,894	7,075,096	6,719,463	6,842,544	38.4%	140,111	2.0%	10.4%	95.1%	96.7%	101.8%	107.1%	105.5
643	Psychostimulant tranq-ilizers	3.94%	7,545,526	7,422,741	7,045,555	7,173,406	40.3%	153,145	2.1%	11.4%	95.1%	96.6%	101.8%	107.1%	105.4
131	Antidiarrheals, w/o antnfctve	3.98%	7,619,799	7,497,986	7,116,845	7,247,553	40.7%	156,094	2.2%	11.6%	95.1%	96.7%	101.8%	107.1%	105.4
671	Barbiturate sedatives	3.99%	7,637,874	7,517,592	7,137,751	7,265,391	40.8%	156,806	2.2%	11.6%	95.1%	96.6%	101.8%	107.0%	105.5
481	Hematinics, ferrous	4.15%	7,682,375	7,561,440	7,179,584	7,308,562	41.1%	158,599	2.2%	11.8%	95.1%	96.7%	101.8%	107.0%	105.5
232	Antispasm., belladonna	4.38%	7,743,562	7,621,243	7,233,859	7,365,615	41.4%	161,097	2.2%	12.0%	95.1%	96.6%	101.8%	107.0%	105.4
784	Digestants, ethical	4.42%	7,759,163	7,636,209	7,250,205	7,382,030	41.5%	161,822	2.2%	12.0%	95.1%	96.7%	101.8%	107.0%	105.5
642	Psychostimulants	4.85%	7,986,655	7,868,724	7,469,439	7,605,857	42.7%	172,673	2.3%	12.8%	95.2%	96.7%	101.8%	106.9%	105.5
202	Anti-parkinsonism, other	4.93%	8,009,376	7,893,470	7,491,908	7,628,738	42.9%	173,801	2.3%	12.9%	95.2%	96.6%	101.8%	106.9%	105.4
644	Lithium products	5.04%	8,025,413	7,909,346	7,506,594	7,643,968	42.9%	174,568	2.3%	13.0%	95.2%	96.6%	101.8%	106.9%	105.4
521	Sex hormones	5.05%	8,501,104	8,389,546	7,947,803	8,094,010	45.5%	197,285	2.4%	14.6%	95.2%	96.5%	101.8%	107.0%	105.6
723	Systemic iodine preparations	5.33%	8,514,055	8,404,349	7,960,991	8,107,649	45.5%	198,012	2.4%	14.7%	95.2%	96.5%	101.8%	106.9%	105.6
302	Other cytostatic drugs	5.73%	8,608,722	8,494,552	8,047,538	8,216,288	46.2%	204,232	2.5%	15.2%	95.4%	96.7%	102.1%	107.0%	105.6
233	Antispasm., w/tranquilizers	5.93%	8,744,126	8,628,301	8,168,477	8,351,462	46.9%	212,245	2.5%	15.8%	95.5%	96.8%	102.2%	107.0%	105.6
236	Pro-motility agents	7.13%	8,806,579	8,689,839	8,221,159	8,410,660	47.2%	216,467	2.6%	16.1%	95.5%	96.8%	102.3%	107.1%	105.7
630	Parasympathetic drugs	7.13%	8,822,465	8,705,113	8,235,803	8,426,975	47.3%	217,631	2.6%	16.2%	95.5%	96.8%	102.3%	107.1%	105.7
234	Antispasm/antisecr., other	7.54%	9,891,907	9,783,202	9,218,854	9,476,878	53.2%	296,745	3.1%	22.0%	95.8%	96.9%	102.8%	107.3%	106.1
393	Insulin/syringe combination	8.01%	9,925,250	9,818,091	9,246,905	9,505,283	53.4%	299,020	3.1%	22.2%	95.8%	96.8%	102.8%	107.3%	[illegible]
762	B-complex vitamins	8.10%	9,945,571	9,838,482	9,265,471	9,524,386	53.5%	300,567	3.2%	22.3%	95.8%	96.8%	102.8%	107.3%	[illegible]
721	Thyroid hormone	8.32%	10,094,616	9,988,922	9,401,625	9,662,193	54.3%	312,034	3.2%	23.2%	95.7%	96.7%	102.8%	107.4%	[illegible]
614	Ophth: Miotics & Glaucoma	8.50%	10,205,583	10,101,611	9,513,240	9,771,546	54.9%	321,329	3.3%	23.8%	95.7%	96.7%	102.7%	107.3%	[illegible]
153	Sulfonamides, systemic	8.95%	10,266,393	10,164,395	9,569,416	9,827,971	55.2%	326,377	3.3%	24.2%	95.7%	96.7%	102.7%	107.3%	[illegible]
783	Specific antagonists	9.26%	10,287,575	10,182,420	9,586,038	9,846,885	55.3%	328,129	3.3%	24.4%	95.7%	96.7%	102.7%	107.3%	[illegible]
91	Antiarthritics, systemic	10.14%	11,961,901	11,863,296	11,078,029	11,473,627	64.4%	493,080	4.3%	36.6%	95.9%	96.7%	103.6%	108.0%	107.1
412	Diuretics, non-injectable	10.34%	13,043,615	12,935,811	12,030,351	12,486,001	70.1%	597,787	4.8%	44.4%	95.7%	96.5%	103.8%	108.4%	[illegible]
282	Chromolyn and similars	10.48%	13,065,698	12,956,895	12,053,435	12,508,620	70.3%	600,157	4.8%	44.5%	95.7%	96.5%	103.8%	108.4%	[illegible]
563	Bulk Producing Laxatives	10.78%	13,072,424	12,962,747	12,058,760	12,515,429	70.3%	600,891	4.8%	44.6%	95.7%	96.5%	103.8%	108.4%	[illegible]
160	Antimalarials	10.82%	13,090,841	12,980,254	12,071,985	12,532,091	70.4%	602,694	4.8%	44.7%	95.7%	96.5%	103.8%	108.4%	[illegible]

TABLE 1: MDO UNDER 65 EXPERIENCE SUMMARY

(1) USC CODE	(2) CLASSIFICATION NAME	(3) % MAIL ORDER BY USC	(4) [CUMULATIVE EXPECTED CHARGES] BY UNITS	(5) BY DAYS	(6) BY PATIENTS	(7) CUMULATIVE CHARGES	(8) PERCENT OF ALL CHARGES	(9) CUMULATIVE MAIL ORDER CHARGES	(10) PERCENT MAIL ORDER	(11) % OF ALL MAIL ORDER	(12) [CUMULATIVE ACTUAL TO EXPECTED] BY UNITS	(13) BY DAYS	(14) BY PATIENTS	(15) UNITS PER PATIENT	(16) DAYS PER PATIENT
281	General Bronchodilators	11.18%	13,518,906	13,418,953	12,448,567	12,944,746	72.7%	648,843	5.0%	48.2%	95.8%	96.5%	104.0%	108.6%	107.8%
820	Needles and syringes	11.85%	13,589,209	13,495,989	12,511,369	13,005,512	73.1%	656,044	5.0%	48.7%	95.7%	96.4%	103.9%	108.6%	107.9%
524	Anabolic Hormones	11.93%	13,592,539	13,500,706	12,517,419	13,008,438	73.1%	656,393	5.0%	48.7%	95.7%	96.4%	103.9%	108.6%	107.9%
111	Anticoagulants, oral	11.98%	13,630,343	13,541,073	12,553,823	13,044,654	73.3%	660,732	5.1%	49.0%	95.7%	96.3%	103.9%	108.6%	107.9%
392	Diabetes therapy, oral	12.27%	13,961,313	13,874,625	12,852,103	13,365,969	75.1%	700,147	5.2%	52.0%	95.7%	96.3%	104.0%	108.6%	108.0%
528	Hormones, other	12.35%	13,971,806	13,885,889	12,863,366	13,374,404	75.1%	701,189	5.2%	52.0%	95.7%	96.3%	104.0%	108.6%	107.9%
315	Digitalis preparations	12.39%	14,021,406	13,936,310	12,908,909	13,417,292	75.4%	706,502	5.3%	52.4%	95.7%	96.3%	103.9%	108.6%	108.0%
120	Anticonvulsants	12.49%	14,159,103	14,077,065	13,034,535	13,546,362	76.1%	722,620	5.3%	53.6%	95.7%	96.2%	103.9%	108.6%	108.0%
314	Beta-blocking agents	13.59%	15,539,272	15,460,303	14,271,312	14,869,014	83.5%	902,349	6.1%	67.0%	95.7%	96.2%	104.2%	108.9%	108.3%
311	Antihypertensive drugs	13.64%	16,447,849	16,372,284	15,094,648	15,738,827	88.4%	1,021,030	6.5%	75.8%	95.7%	96.1%	104.3%	109.0%	108.5%
312	Vasodilators	14.29%	17,077,955	17,004,723	15,658,136	16,336,217	91.8%	1,106,419	6.8%	82.1%	95.7%	96.1%	104.3%	109.1%	108.6%
601	Potassium supplements	14.41%	17,337,571	17,285,798	15,903,874	16,593,815	93.2%	1,143,526	6.9%	84.9%	95.7%	96.0%	104.3%	109.0%	108.7%
93	Gout-specific preparations	14.53%	17,483,933	17,435,019	16,035,250	16,732,070	94.0%	1,163,614	7.0%	86.4%	95.7%	96.0%	104.3%	109.0%	108.7%
391	Diabetes therapy, insulin	14.66%	17,805,315	17,773,231	16,328,898	17,020,640	95.6%	1,205,923	7.1%	89.5%	95.6%	95.8%	104.2%	109.0%	108.8%
201	Anti-parkinsonism, L-Dopa	14.75%	17,831,840	17,801,409	16,353,309	17,046,098	95.7%	1,209,679	7.1%	89.8%	95.6%	95.8%	104.2%	109.0%	108.9%
321	Chlolesterol reducers	15.12%	17,940,743	17,909,423	16,450,491	17,154,311	96.4%	1,226,041	7.1%	91.0%	95.6%	95.8%	104.3%	109.1%	108.9%
781	Crude Drugs & Chemicals	16.51%	17,944,156	17,911,614	16,451,525	17,155,934	96.4%	1,226,309	7.1%	91.0%	95.6%	95.8%	104.3%	109.1%	108.9%
317	Calcium channel blockers	17.11%	18,330,666	18,296,303	16,796,175	17,532,705	98.5%	1,290,786	7.4%	95.8%	95.6%	95.8%	104.4%	109.1%	108.9%
313	Anti-arrhythmia agents	17.49%	18,565,630	18,529,442	17,004,008	17,759,145	99.8%	1,330,381	7.5%	98.7%	95.7%	95.8%	104.4%	109.2%	109.0%
526	Mineralocorticoids	18.68%	18,568,158	18,532,460	17,006,300	17,761,436	99.8%	1,330,809	7.5%	98.8%	95.7%	95.8%	104.4%	109.2%	109.0%
303	Immunosuppressive drugs	37.69%	18,594,326	18,553,456	17,024,495	17,798,904	100.0%	1,344,932	7.6%	99.8%	95.7%	95.9%	104.5%	109.2%	109.0%
283	Bronchial Mucolytics	60.33%	18,598,267	18,559,691	17,027,246	17,802,824	100.0%	1,347,297	7.6%	100.0%	95.7%	95.9%	104.6%	109.2%	109.0%
998	Total	7.57%	18,598,267	18,559,691	17,027,246	17,802,824		1,347,297			95.7%	95.9%	104.6%	109.2%	109.0%

TABLE 2: MDO OVER 65 EXPERIENCE SUMMARY

(1) USC CODE	(2) CLASSIFICATION NAME	(3) % MAIL ORDER BY USC	(4) [CUMULATIVE EXPECTED CHARGES] BY UNITS	(5) BY DAYS	(6) BY PATIENTS	(7) CUMULATIVE CHARGES	(8) PERCENT OF ALL CHARGES	(9) CUMULATIVE MAIL ORDER CHARGES	(10) PERCENT MAIL ORDER	(11) % OF ALL MAIL ORDER	(12) [CUMULATIVE ACTUAL TO EXPECTED] BY UNITS	(13) BY DAYS	(14) BY PATIENTS	(15) UNITS PER PATIENT	(16) DAYS PER PATIENT
435	Enzymes, fibrinolytic	0.00%	2,867	2,191	2,525	2,946	0.0%	0	0.0%	0.0%	102.8%	134.5%	116.7%	113.5%	86.8
483	Hematinics, vitamin B12	0.00%	6,381	4,600	4,841	5,465	0.1%	0	0.0%	0.0%	85.6%	118.8%	112.9%	131.8%	95.0
431	Enzymes, topical	0.00%	8,746	6,587	7,287	7,974	0.1%	0	0.0%	0.0%	91.2%	121.1%	109.4%	120.0%	90.4
607	Nutrients & supplements, other	0.00%	9,090	7,387	7,805	8,694	0.1%	0	0.0%	0.0%	95.6%	117.7%	111.4%	116.5%	94.6
51	Antacids	0.00%	9,265	7,570	7,843	8,796	0.1%	0	0.0%	0.0%	94.9%	116.2%	112.1%	118.1%	96.5
152	Penicillins	0.23%	28,282	24,920	26,338	24,719	0.3%	36	0.1%	0.0%	87.4%	99.2%	93.9%	107.4%	94.6
344	Preps-cough only	0.44%	52,008	49,605	50,318	48,489	0.7%	140	0.3%	0.0%	93.2%	97.7%	96.4%	103.4%	93.6
613	Ophth: decongestants	0.48%	56,616	53,548	54,455	52,650	0.7%	160	0.3%	0.0%	93.0%	98.3%	96.7%	104.0%	93.5
151	Antibiotics, broad & medium	0.71%	315,551	326,706	300,398	311,662	4.2%	1,999	0.6%	0.3%	98.8%	95.4%	103.7%	105.0%	108.8
182	Anti-obesity, other preps.	0.75%	322,874	334,717	308,878	319,695	4.3%	2,059	0.6%	0.3%	99.0%	95.5%	103.5%	104.5%	108.4
523	Corticoids in combinations	0.89%	367,762	382,668	353,628	364,372	4.9%	2,456	0.7%	0.4%	99.1%	95.2%	103.0%	104.0%	108.2
616	Ophth: Anti-infectives	0.94%	378,658	393,122	365,071	375,491	5.1%	2,560	0.7%	0.4%	99.2%	95.5%	102.9%	103.7%	107.7
343	Cough/cold preparations	1.06%	404,189	418,601	390,264	398,538	5.4%	2,804	0.7%	0.4%	98.6%	95.2%	102.1%	103.6%	107.5
22	Analgesics, narcotic	1.24%	502,575	514,094	474,441	489,576	6.6%	3,933	0.8%	0.6%	97.4%	95.2%	103.2%	105.9%	108.4
644	Lithium products	1.41%	504,373	515,655	475,918	491,137	6.6%	3,955	0.8%	0.6%	97.4%	95.2%	103.2%	106.0%	108.5
783	Specific antagonists	1.44%	506,817	517,820	478,317	493,423	6.7%	3,988	0.8%	0.6%	97.4%	95.3%	103.2%	106.0%	108.5
788	All other misc. ethical drugs	1.48%	523,931	529,024	488,769	506,218	6.8%	4,177	0.8%	0.6%	96.6%	95.7%	103.6%	107.2%	108.2
301	Anti-Leukemia Drugs	1.62%	527,843	532,719	492,504	509,372	6.9%	4,228	0.8%	0.6%	96.5%	95.6%	103.4%	107.2%	108.2
131	Antidiarrheals, w/o antnfctve	1.91%	556,476	559,384	518,045	537,069	7.3%	4,757	0.9%	0.7%	96.5%	96.0%	103.7%	107.4%	108.0
236	Pro-motility agents	1.97%	578,867	583,833	543,646	561,323	7.6%	5,234	0.9%	0.8%	97.0%	96.1%	103.3%	106.5%	107.4
563	Bulk Producing Laxatives	2.18%	584,093	587,911	548,331	566,139	7.7%	5,339	0.9%	0.8%	96.9%	96.3%	103.2%	106.5%	107.2
690	Proprietary Smoking Deterant	2.40%	591,548	595,968	556,057	573,475	7.8%	5,515	1.0%	0.8%	96.9%	96.2%	103.1%	106.4%	107.2
492	Hemorrhoidal preps. w/cort.	2.40%	603,167	606,569	567,256	583,309	7.9%	5,751	1.0%	0.8%	96.7%	96.2%	102.8%	106.3%	106.9
372	Anti-infectives, topical	2.42%	609,509	611,019	572,989	588,474	8.0%	5,876	1.0%	0.9%	96.5%	96.3%	102.7%	106.4%	106.6
155	Trimethoprim	2.52%	666,207	663,938	620,892	638,781	8.6%	7,145	1.1%	1.0%	95.9%	96.2%	102.9%	107.3%	106.9
376	Anti-dandruff preparations	2.76%	668,116	665,756	622,740	640,485	8.7%	7,192	1.1%	1.1%	95.9%	96.2%	102.8%	107.3%	106.9
526	Mineralocorticoids	2.79%	669,925	666,953	623,614	642,134	8.7%	7,238	1.1%	1.1%	95.9%	96.3%	103.0%	107.4%	106.9
170	Antinauseants	2.95%	721,574	718,648	677,621	690,809	9.3%	8,672	1.3%	1.3%	95.7%	96.1%	101.9%	106.5%	[illegible]
12	Trichomonacides	3.11%	724,862	722,549	680,627	694,478	9.4%	8,786	1.3%	1.3%	95.8%	96.1%	102.0%	106.5%	[illegible]
231	Antispasm., synthetic	3.17%	744,844	741,201	699,293	713,514	9.6%	9,390	1.3%	1.4%	95.8%	96.3%	102.0%	106.5%	[illegible]
671	Barbiturate sedatives	3.32%	755,091	753,745	710,722	723,754	9.8%	9,730	1.3%	1.4%	95.8%	96.0%	101.8%	106.2%	[illegible]

TABLE 2: MDO OVER 65 EXPERIENCE SUMMARY

(1) USC CODE	(2) CLASSIFICATION NAME	(3) % MAIL ORDER BY USC	(4) [CUMULATIVE	(5) EXPECTED CHARGES]	(6)	(7) CUMULATIVE CHARGES	(8) PERCENT OF ALL CHARGES	(9) CUMULATIVE MAIL ORDER CHARGES	(10) PERCENT MAIL ORDER	(11) % OF ALL MAIL ORDER	(12) [CUMULATIVE	(13) ACTUAL TO	(14) EXPECTED]	(15) UNITS PER PATIENT	(16) DAYS PER PATIENT
			BY UNITS	BY DAYS	BY PATIENTS						BY UNITS	BY DAYS	BY PATIENTS		
630	Parasympathetic drugs	3.38%	765,662	766,382	719,674	735,173	9.9%	10,116	1.4%	1.5%	96.0%	95.9%	102.2%	106.4%	106.5
591	Muscle relaxants, non-surgical	3.49%	831,802	837,680	784,577	801,052	10.8%	12,417	1.6%	1.8%	96.3%	95.6%	102.1%	106.0%	106.8
672	Non-barbiturate sedatives	3.53%	913,799	922,056	859,399	879,200	11.9%	15,179	1.7%	2.2%	96.2%	95.4%	102.3%	106.3%	107.3
641	Tranquilizers	4.19%	1,267,149	1,278,945	1,192,564	1,223,152	16.5%	29,574	2.4%	4.3%	96.5%	95.6%	102.6%	106.3%	107.2
21	Analgesics, non-narcotic	4.73%	1,429,261	1,436,654	1,344,187	1,378,982	18.6%	36,949	2.7%	5.4%	96.5%	96.0%	102.6%	106.3%	106.9
522	Corticoids, plain	4.78%	1,610,910	1,621,796	1,517,541	1,554,929	21.0%	45,352	2.9%	6.7%	96.5%	95.9%	102.5%	106.2%	106.9
484	Hematinics, other	4.80%	1,612,446	1,623,673	1,519,251	1,556,367	21.0%	45,421	2.9%	6.7%	96.5%	95.9%	102.4%	106.1%	106.9
643	Psychostimulants	4.99%	1,695,042	1,706,627	1,598,117	1,637,575	22.1%	49,475	3.0%	7.3%	96.6%	96.0%	102.5%	106.1%	106.8
341	Oral cold preparations	5.33%	1,744,199	1,759,341	1,649,850	1,689,276	22.8%	52,232	3.1%	7.7%	96.9%	96.0%	102.4%	105.7%	106.6
614	Ophth: Miotics & Glaucoma	5.84%	1,906,765	1,919,467	1,798,629	1,843,701	24.9%	61,256	3.3%	9.0%	96.7%	96.1%	102.5%	106.0%	106.7
642	Psychostimulants	5.98%	1,974,025	1,985,259	1,862,049	1,908,229	25.8%	65,113	3.4%	9.6%	96.7%	96.1%	102.5%	106.0%	106.6
153	Sulfonamides, systemic	6.10%	1,985,386	1,997,374	1,870,373	1,918,118	25.9%	65,716	3.4%	9.6%	96.6%	96.0%	102.6%	106.1%	106.8
762	B-complex vitamins	6.18%	1,993,205	2,004,996	1,876,747	1,925,725	26.0%	66,186	3.4%	9.7%	96.6%	96.0%	102.6%	106.2%	106.8
393	Insulin/syringe combination	6.40%	1,996,575	2,008,866	1,881,922	1,928,879	26.1%	66,388	3.4%	9.7%	96.6%	96.0%	102.5%	106.1%	106.7
141	Antihistamines, caps & tabs	6.41%	2,021,719	2,033,639	1,905,354	1,950,277	26.4%	67,759	3.5%	9.9%	96.5%	95.9%	102.4%	106.1%	106.7
374	Fungicides	6.42%	2,058,251	2,071,119	1,940,988	1,984,280	26.8%	69,941	3.5%	10.3%	96.4%	95.8%	102.2%	106.0%	106.7
763	Other ethical vitamins	6.46%	2,060,162	2,073,316	1,942,546	1,986,153	26.9%	70,062	3.5%	10.3%	96.4%	95.8%	102.2%	106.1%	106.7
202	Anti-parkinsonism, other	6.88%	2,081,722	2,094,255	1,960,386	2,004,687	27.1%	71,337	3.6%	10.5%	96.3%	95.7%	102.3%	106.2%	106.8
761	Multivitamins	7.08%	2,087,354	2,100,046	1,965,251	2,010,480	27.2%	71,747	3.6%	10.5%	96.3%	95.7%	102.3%	106.2%	106.9
481	Hematinics, ferrous	7.28%	2,102,240	2,115,073	1,981,670	2,025,774	27.4%	72,861	3.6%	10.7%	96.4%	95.8%	102.2%	106.1%	106.7
233	Antispasm., w/tranquilizers	7.32%	2,137,727	2,151,676	2,015,096	2,062,013	27.9%	75,512	3.7%	11.1%	96.5%	95.8%	102.3%	106.1%	106.8
391	Diabetes therapy, insulin	7.81%	2,278,434	2,291,626	2,143,460	2,196,395	29.7%	86,004	3.9%	12.6%	96.4%	95.8%	102.5%	106.3%	106.9
302	Other cytostatic drugs	7.85%	2,323,874	2,347,172	2,187,517	2,246,866	30.4%	89,968	4.0%	13.2%	96.7%	95.7%	102.7%	106.2%	107.3
373	Antipruritics	8.20%	2,328,201	2,352,849	2,194,009	2,252,047	30.4%	90,393	4.0%	13.3%	96.7%	95.7%	102.6%	106.1%	107.[illegible]
723	Systemic iodine preparations	8.40%	2,333,652	2,359,276	2,200,643	2,256,966	30.5%	90,806	4.0%	13.3%	96.7%	95.7%	102.6%	106.0%	107.[illegible]
232	Antispasm., belladonna	8.52%	2,349,917	2,375,978	2,217,072	2,272,365	30.7%	92,118	4.1%	13.5%	96.7%	95.6%	102.5%	106.0%	107.[illegible]
315	Digitalis preparations	8.52%	2,417,040	2,443,554	2,280,080	2,333,412	31.5%	97,322	4.2%	14.3%	96.5%	95.5%	102.3%	106.0%	107.[illegible]
234	Antispasm/antisecr., other	8.67%	2,817,848	2,834,030	2,642,016	2,718,565	36.8%	130,714	4.8%	19.2%	96.5%	95.9%	102.9%	106.7%	107.[illegible]
154	Urinary antibacterials	8.72%	2,857,355	2,878,597	2,679,976	2,757,254	37.3%	134,086	4.9%	19.7%	96.5%	95.8%	102.9%	106.6%	107.[illegible]
602	Supplements: Fluorides	9.05%	2,858,508	2,880,097	2,681,481	2,758,602	37.3%	134,208	4.9%	19.7%	96.5%	95.8%	102.9%	106.6%	107.[illegible]
820	Needles and syringes	9.23%	2,898,556	2,922,154	2,715,630	2,795,402	37.8%	137,603	4.9%	20.2%	96.4%	95.7%	102.9%	106.7%	1[illegible]

TABLE 2: MDO OVER 65 EXPERIENCE SUMMARY

(1) USC CODE	(2) CLASSIFICATION NAME	(3) % MAIL ORDER BY USC	(4) [CUMULATIVE EXPECTED CHARGES] BY UNITS	(5) BY DAYS	(6) BY PATIENTS]	(7) CUMULATIVE CHARGES	(8) PERCENT OF ALL CHARGES	(9) CUMULATIVE MAIL ORDER CHARGES	(10) PERCENT MAIL ORDER	(11) % OF ALL MAIL ORDER	(12) [CUMULATIVE ACTUAL TO EXPECTED] BY UNITS	(13) BY DAYS	(14) BY PATIENTS]	(15) UNITS PER PATIENT	(16) DAYS PER PATIENT
412	Diuretics, non-injectable	9.75%	3,470,300	3,499,864	3,228,207	3,335,898	45.1%	190,317	5.7%	27.9%	96.1%	95.3%	103.3%	107.5%	108.4%
721	Thyroid hormone	10.23%	3,514,728	3,544,158	3,268,368	3,377,546	45.7%	194,579	5.8%	28.5%	96.1%	95.3%	103.3%	107.5%	108.4%
235	Urinary tract antispasmodics	10.34%	3,526,465	3,555,005	3,278,195	3,388,805	45.8%	195,743	5.8%	28.7%	96.1%	95.3%	103.4%	107.6%	108.4%
521	Sex hormones	10.41%	3,597,473	3,626,045	3,346,383	3,455,706	46.7%	202,705	5.9%	29.7%	96.1%	95.3%	103.3%	107.5%	108.4%
120	Anticonvulsants	10.61%	3,637,577	3,668,265	3,383,365	3,493,818	47.2%	206,748	5.9%	30.3%	96.0%	95.2%	103.3%	107.5%	108.4%
281	General Bronchodilators	10.79%	3,877,998	3,908,416	3,585,847	3,716,659	50.3%	230,792	6.2%	33.9%	95.8%	95.1%	103.6%	108.1%	[illegible]
392	Diabetes therapy, oral	10.84%	4,102,445	4,131,010	3,792,415	3,938,379	53.2%	254,826	6.5%	37.4%	96.0%	95.3%	103.8%	108.2%	[illegible]
91	Antiarthritics, systemic	11.12%	4,924,466	4,955,615	4,529,327	4,734,590	64.0%	343,362	7.3%	50.4%	96.1%	95.5%	104.5%	108.7%	[illegible]
311	Antihypertensive drugs	11.21%	5,481,981	5,526,442	5,034,090	5,275,999	71.3%	404,074	7.7%	59.3%	96.2%	95.5%	104.8%	108.9%	[illegible]
312	Vasodilators	11.52%	6,161,043	6,219,172	5,667,259	5,966,816	80.7%	483,676	8.1%	71.0%	96.8%	95.9%	105.3%	108.7%	[illegible]
111	Anticoagulants, oral	12.16%	6,187,927	6,248,181	5,693,428	5,992,480	81.0%	486,798	8.1%	71.4%	96.8%	95.9%	105.3%	108.7%	[illegible]
601	Potassium supplements	12.26%	6,372,364	6,443,036	5,867,264	6,181,917	83.6%	510,021	8.3%	74.8%	97.0%	95.9%	105.4%	108.6%	[illegible]
93	Gout-specific preparations	13.22%	6,461,175	6,532,892	5,944,901	6,266,347	84.7%	521,181	8.3%	76.5%	97.0%	95.9%	105.4%	108.7%	[illegible]
317	Calcium channel blockers	13.31%	6,738,783	6,801,360	6,184,387	6,541,669	88.4%	557,832	8.5%	81.8%	97.1%	96.2%	105.8%	109.0%	110.0%
282	Chromolyn and similars	13.75%	6,741,982	6,804,093	6,187,438	6,544,717	88.5%	558,251	8.5%	81.9%	97.1%	96.2%	105.8%	109.0%	110.0%
314	Beta-blocking agents	13.81%	7,262,181	7,340,169	6,660,486	7,052,966	95.4%	628,439	8.9%	92.2%	97.1%	96.1%	105.9%	109.0%	110.2%
201	Anti-parkinsonism, L-Dopa	14.15%	7,327,228	7,403,746	6,715,537	7,116,668	96.2%	637,455	9.0%	93.5%	97.1%	96.1%	106.0%	109.1%	110.2%
321	Chlolesterol reducers	14.28%	7,367,619	7,448,128	6,755,742	7,156,993	96.8%	643,183	9.0%	94.4%	97.1%	96.1%	105.9%	109.1%	110.2%
313	Anti-arrhythmia agents	15.37%	7,580,200	7,667,029	6,952,438	7,368,912	99.6%	675,761	9.2%	99.1%	97.2%	96.1%	106.0%	109.0%	110.3%
784	Digestants, ethical	16.36%	7,591,050	7,677,144	6,960,001	7,379,058	99.8%	677,421	9.2%	99.4%	97.2%	96.1%	106.0%	109.1%	110.3%
617	Ophth: other	17.37%	7,591,728	7,677,668	6,960,201	7,379,438	99.8%	677,487	9.2%	99.4%	97.2%	96.1%	106.0%	109.1%	110.3%
528	Hormones, other	18.25%	7,598,672	7,682,419	6,963,739	7,384,303	99.8%	678,375	9.2%	99.5%	97.2%	96.1%	106.0%	109.1%	110.3%
740	Tuberculosis therapy	23.31%	7,603,778	7,687,552	6,968,315	7,389,700	99.9%	679,633	9.2%	99.7%	97.2%	96.1%	106.0%	109.1%	110.3%
781	Crude Drugs & Chemicals	24.39%	7,604,967	7,688,742	6,969,319	7,390,520	99.9%	679,833	9.2%	99.7%	97.2%	96.1%	106.0%	109.1%	110.3%
160	Antimalarials	25.31%	7,608,870	7,692,297	6,971,710	7,395,167	100.0%	681,009	9.2%	99.9%	97.2%	96.1%	106.1%	109.1%	110.3%
450	Feminine hygiene preparations	47.33%	7,609,111	7,692,892	6,971,809	7,395,410	100.0%	681,124	9.2%	99.9%	97.2%	96.1%	106.1%	109.1%	110.3%
611	Ophth: mydriatics	65.51%	7,610,112	7,693,190	6,971,981	7,396,129	100.0%	681,595	9.2%	100.0%	97.2%	96.1%	106.1%	109.2%	110.3%
998	Total	9.22%	7,610,112	7,693,190	6,971,981	7,396,129		681,595			97.2%	96.1%	106.1%	109.2%	110.3%

TABLE 3: MDO EXPERIENCE HIGHLIGHTS

	UNDER AGE 65 (TABLE 1)			OVER AGE 65 (TABLE 2)		
	(8) PERCENT OF ALL CHARGES	(10) PERCENT MAIL ORDER	(14) ACTUAL TO EXPECTED CHARGES	(8) PERCENT OF ALL CHARGES	(10) PERCENT MAIL ORDER	(14) ACTUAL TO EXPECTED CHARGES
1	0.1%	0.0%	96.2%	0.0%	0.0%	116.7%
2	0.6%	0.1%	95.6%	0.1%	0.0%	112.9%
3	0.7%	0.1%	97.4%	0.1%	0.0%	109.4%
4	1.5%	0.2%	96.5%	0.1%	0.0%	111.4%
5	1.7%	0.2%	96.7%	0.1%	0.0%	112.1%
6	2.4%	0.3%	97.5%	0.3%	0.1%	93.9%
7	3.1%	0.3%	99.4%	0.7%	0.3%	96.4%
8	11.0%	0.4%	100.5%	0.7%	0.3%	96.7%
9	13.1%	0.4%	100.9%	4.2%	0.6%	103.7%
10	13.8%	0.4%	100.8%	4.3%	0.6%	103.5%
11	13.9%	0.4%	100.8%	4.9%	0.7%	103.0%
12	13.9%	0.4%	100.8%	5.1%	0.7%	102.9%
13	14.7%	0.5%	100.5%	5.4%	0.7%	102.1%
14	15.0%	0.5%	100.5%	6.6%	0.8%	103.2%
15	15.1%	0.5%	100.4%	6.6%	0.8%	103.2%
16	15.3%	0.5%	100.4%	6.7%	0.8%	103.2%
17	16.1%	0.5%	100.5%	6.8%	0.8%	103.6%
18	16.5%	0.6%	100.1%	6.9%	0.8%	103.4%
19	16.9%	0.6%	100.1%	7.3%	0.9%	103.7%
20	17.4%	0.6%	100.0%	7.6%	0.9%	103.3%
21	18.9%	0.7%	100.0%	7.7%	0.9%	103.2%
22	19.6%	0.8%	100.2%	7.8%	1.0%	103.1%
23	20.0%	0.8%	100.3%	7.9%	1.0%	102.8%
24	20.5%	0.9%	100.0%	8.0%	1.0%	102.7%
25	20.5%	0.9%	100.0%	8.6%	1.1%	102.9%
26	20.6%	0.9%	100.0%	8.7%	1.1%	102.8%
27	20.9%	0.9%	100.0%	8.7%	1.1%	103.0%
28	21.4%	1.0%	100.1%	9.3%	1.3%	101.9%
29	27.9%	1.5%	101.6%	9.4%	1.3%	102.0%
30	31.1%	1.7%	102.4%	9.6%	1.3%	102.0%
31	31.1%	1.7%	102.3%	9.8%	1.3%	101.8%
32	32.9%	1.8%	102.4%	9.9%	1.4%	102.2%
33	36.1%	1.9%	102.1%	10.8%	1.6%	102.1%
34	36.2%	1.9%	102.1%	11.9%	1.7%	102.3%
35	38.4%	2.0%	101.8%	16.5%	2.4%	102.6%
36	40.3%	2.1%	101.8%	18.6%	2.7%	102.6%
37	40.7%	2.2%	101.8%	21.0%	2.9%	102.5%
38	40.8%	2.2%	101.8%	21.0%	2.9%	102.4%
39	41.1%	2.2%	101.8%	22.1%	3.0%	102.5%
40	41.4%	2.2%	101.8%	22.8%	3.1%	102.4%
41	41.5%	2.2%	101.8%	24.9%	3.3%	102.5%
42	42.7%	2.3%	101.8%	25.8%	3.4%	102.5%
43	42.9%	2.3%	101.8%	25.9%	3.4%	102.6%
44	42.9%	2.3%	101.8%	26.0%	3.4%	102.6%
45	45.5%	2.4%	101.8%	26.1%	3.4%	102.5%
46	45.5%	2.4%	101.8%	26.4%	3.5%	102.4%
47	46.2%	2.5%	102.1%	26.8%	3.5%	102.2%

TABLE 3: MDO EXPERIENCE HIGHLIGHTS

	UNDER AGE 65 (TABLE 1)			OVER AGE 65 (TABLE 2)		
	(8) PERCENT OF ALL CHARGES	(10) PERCENT MAIL ORDER	(14) ACTUAL TO EXPECTED CHARGES	(8) PERCENT OF ALL CHARGES	(10) PERCENT MAIL ORDER	(14) ACTUAL TO EXPECTED CHARGES
48	46.9%	2.5%	102.2%	26.9%	3.5%	102.2%
49	47.2%	2.6%	102.3%	27.1%	3.6%	102.3%
50	47.3%	2.6%	102.3%	27.2%	3.6%	102.3%
51	53.2%	3.1%	102.8%	27.4%	3.6%	102.2%
52	53.4%	3.1%	102.8%	27.9%	3.7%	102.3%
53	53.5%	3.2%	102.8%	29.7%	3.9%	102.5%
54	54.3%	3.2%	102.8%	30.4%	4.0%	102.7%
55	54.9%	3.3%	102.7%	30.4%	4.0%	102.6%
56	55.2%	3.3%	102.7%	30.5%	4.0%	102.6%
57	55.3%	3.3%	102.7%	30.7%	4.1%	102.5%
58	64.4%	4.3%	103.6%	31.5%	4.2%	102.3%
59	70.1%	4.8%	103.8%	36.8%	4.8%	102.9%
60	70.3%	4.8%	103.8%	37.3%	4.9%	102.9%
61	70.3%	4.8%	103.8%	37.3%	4.9%	102.9%
62	70.4%	4.8%	103.8%	37.8%	4.9%	102.9%
63	72.7%	5.0%	104.0%	45.1%	5.7%	103.3%
64	73.1%	5.0%	103.9%	45.7%	5.8%	103.3%
65	73.1%	5.0%	103.9%	45.8%	5.8%	103.4%
66	73.3%	5.1%	103.9%	46.7%	5.9%	103.3%
67	75.1%	5.2%	104.0%	47.2%	5.9%	103.3%
68	75.1%	5.2%	104.0%	50.3%	6.2%	103.6%
69	75.4%	5.3%	103.9%	53.2%	6.5%	103.8%
70	76.1%	5.3%	103.9%	64.0%	7.3%	104.5%
71	83.5%	6.1%	104.2%	71.3%	7.7%	104.8%
72	88.4%	6.5%	104.3%	80.7%	8.1%	105.3%
73	91.8%	6.8%	104.3%	81.0%	8.1%	105.3%
74	93.2%	6.9%	104.3%	83.6%	8.3%	105.4%
75	94.0%	7.0%	104.3%	84.7%	8.3%	105.4%
76	95.6%	7.1%	104.2%	88.4%	8.5%	105.8%
77	95.7%	7.1%	104.2%	88.5%	8.5%	105.8%
78	96.4%	7.1%	104.3%	95.4%	8.9%	105.9%
79	96.4%	7.1%	104.3%	96.2%	9.0%	106.0%
80	98.5%	7.4%	104.4%	96.8%	9.0%	105.9%
81	99.8%	7.5%	104.4%	99.6%	9.2%	106.0%
82	99.8%	7.5%	104.4%	99.8%	9.2%	106.0%
83	100.0%	7.6%	104.5%	99.8%	9.2%	106.0%
84	100.0%	7.6%	104.6%	99.8%	9.2%	106.0%
85				99.9%	9.2%	106.0%
86				99.9%	9.2%	106.0%
87				100.0%	9.2%	106.1%
88				100.0%	9.2%	106.1%
89				100.0%	9.2%	106.1%

TABLE 4: MDO ACTUAL TO EXPECTED EXPERIENCE SUMMARY

Group	Segment	(1) MAIL ORDER PERCENT RANGE	(2) [EXPECTED CHARGES] BY UNITS	(3) BY DAYS	(4) BY PATIENTS	(5) ACTUAL CHARGES	(6) PERCENT OF ALL CHARGES	(7) MAIL ORDER CHARGES	(8) MAIL ORDER PERCENT	(9) PERCENT OF MAIL ORDER	(10) [ACTUAL TO EXPECTED] BY UNITS	(11) BY DAYS	(12) BY PATIENTS	(13) UNITS PER PATIENT	(14) DAYS PER PATIENT
UNDER 65:	1st Quartile	0.0% to 3.1%	4,675,836	4,591,697	4,406,037	4,450,706	25.0%	56,646	1.3%	4.2%	95.2%	96.9%	101.0%	106.1%	104.[illegible]%
	2nd Quartile	3.1% to 7.3%	4,629,896	4,600,589	4,273,993	4,450,706	25.0%	196,736	4.4%	14.6%	96.1%	96.7%	104.1%	108.3%	10[illegible].[illegible]%
	3rd Quartile	7.3% to 12.3%	4,641,314	4,667,959	4,159,215	4,450,706	25.0%	445,066	10.0%	33.0%	95.9%	95.3%	107.0%	111.6%	11[illegible].[illegible]%
	4th Quartile	12.3% to 60.3%	4,651,221	4,699,445	4,188,001	4,450,706	25.0%	648,849	14.6%	48.2%	95.7%	94.7%	106.3%	111.1%	11[illegible].[illegible]%
UNDER 65:	TOTAL	0.0% to 60.3%	18,598,267	18,559,691	17,027,246	17,802,824	100.0%	1,347,297	7.6%	100.0%	95.7%	95.9%	104.6%	109.2%	109.0%
OVER 65:	1st Quartile	0.0% to 5.9%	1,912,322	1,924,902	1,803,868	1,849,032	25.0%	61,575	3.3%	9.0%	96.7%	96.1%	102.5%	106.0%	106.[illegible]%
	2nd Quartile	5.9% to 10.8%	1,945,615	1,963,475	1,765,083	1,849,032	25.0%	167,211	9.0%	24.5%	95.0%	94.2%	104.8%	110.2%	111.2%
	3rd Quartile	10.8% to 11.3%	1,890,529	1,908,698	1,713,614	1,849,032	25.0%	206,527	11.2%	30.3%	97.8%	96.9%	107.9%	110.3%	111.4%
	4th Quartile	11.3% to 47.3%	1,861,646	1,896,115	1,689,416	1,849,032	25.0%	246,283	13.3%	36.1%	99.3%	97.5%	109.4%	110.2%	112.[illegible]%
OVER 65:	TOTAL	0.0% to 47.3%	7,610,112	7,693,190	6,971,981	7,396,129	100.0%	681,595	9.2%	100.0%	97.2%	96.1%	106.1%	109.2%	110.[illegible]%
ALL AGES:	TOTAL		26,208,379	26,252,882	23,999,228	25,198,953	100.0%	2,028,892	8.1%	100.0%	96.1%	96.0%	105.0%	109.2%	109.4%

TABLE 5A: COMPARISON OF ACTUAL TO EXPECTED MDO CARD COSTS

	EXPECTED COSTS	ACTUAL MDO COSTS	ACTUAL TO EXPECTED	EXCESS MDO COST	MAIL ORDER COSTS	EXCESS COST AS AS PERCENT OF MAIL ORDER
UNDER 65: Charges	17,027,246	17,802,824	104.6%	775,578	1,347,297	57.6%
* Prescriptions	1,141,693	1,166,231	102.1%	24,538	25,512	96.2%
Admin Fee	0.67	0.67			0.67	
	....	....			....	
Admin Cost	764,934	781,375	102.1%	16,440	17,093	96.2%
Cost by Deductible						
$0.00	17,792,180	18,584,199	104.5%	792,018	1,364,390	58.0%
$1.00	16,650,487	17,417,968	104.6%	767,480	1,347,297	57.0%
$2.00	15,508,794	16,251,737	104.8%	742,942	1,330,204	55.9%
$3.00	14,367,101	15,085,506	105.0%	718,404	1,313,111	54.7%
$4.00	13,225,408	13,919,275	105.2%	693,866	1,296,018	53.5%
$5.00	12,083,715	12,753,044	105.5%	669,328	1,278,925	52.3%
OVER 65: Charges	6,971,981	7,396,129	106.1%	424,148	681,414	62.2%
* Prescriptions	430,490	443,952	103.1%	13,462	16,045	83.9%
Admin Fee	0.67	0.67			0.67	
	....	....			....	
Admin Cost	288,428	297,448	103.1%	9,020	10,750	83.9%
Cost by Deductible						
$0.00	7,260,409	7,693,577	106.0%	433,168	692,164	62.6%
$1.00	6,829,919	7,249,625	106.1%	419,706	676,119	62.1%
$2.00	6,399,429	6,805,673	106.3%	406,244	660,074	61.5%
$3.00	5,968,939	6,361,721	106.6%	392,782	644,029	61.0%
$4.00	5,538,449	5,917,769	106.8%	379,320	627,984	60.4%
$5.00	5,107,959	5,473,817	107.2%	365,858	611,939	59.8%
TOTAL MDO:Charges	23,999,227	25,198,953	105.0%	1,199,726	2,028,711	59.1%
* Prescriptions	1,572,183	1,610,183	102.4%	38,000	41,557	91.4%
Admin Fee	0.67	0.67			0.67	
	....	....			....	
Admin Cost	1,053,363	1,078,823	102.4%	25,460	27,843	91.4%
Cost by Deductible						
$0.00	25,052,590	26,277,776	104.9%	1,225,186	2,056,554	59.6%
$1.00	23,480,407	24,667,593	105.1%	1,187,186	2,014,997	58.9%
$2.00	21,908,224	23,057,410	105.2%	1,149,186	1,973,440	58.2%
$3.00	20,336,041	21,447,227	105.5%	1,111,186	1,931,883	57.5%
$4.00	18,763,858	19,837,044	105.7%	1,073,186	1,890,326	56.8%
$5.00	17,191,675	18,226,861	106.0%	1,035,186	1,848,769	56.0%

* Expected Prescriptions Projected by Applying CG1 Claims per Patient Parameters.

TABLE 5B: COMPARISON OF ACTUAL TO EXPECTED MDO CARD COSTS

	EXPECTED COSTS	ACTUAL MDO COSTS	ACTUAL TO EXPECTED	EXCESS MDO COST	MAIL ORDER COSTS	EXCESS COST AS AS PERCENT OF MAIL ORDER
UNDER 65: Charges	17,027,246	17,802,824	104.6%	775,578	1,347,297	57.6%
* Prescriptions	1,184,116	1,166,231	98.5%	(17,885)	25,512	-70.1%
Admin Fee	0.67	0.67			0.67	
	....	....			....	
Admin Cost	793,358	781,375	98.5%	(11,983)	17,093	-70.1%
Cost by Deductible						
$0.00	17,820,604	18,584,199	104.3%	763,595	1,364,390	56.0%
$1.00	16,636,488	17,417,968	104.7%	781,480	1,347,297	58.0%
$2.00	15,452,371	16,251,737	105.2%	799,366	1,330,204	60.1%
$3.00	14,268,255	15,085,506	105.7%	817,251	1,313,111	62.2%
$4.00	13,084,138	13,919,275	106.4%	835,136	1,296,018	64.4%
$5.00	11,900,022	12,753,044	107.2%	853,022	1,278,925	66.7%
OVER 65: Charges	6,971,981	7,396,129	106.1%	424,148	681,414	62.2%
* Prescriptions	451,758	443,952	98.3%	(7,806)	16,045	-48.6%
Admin Fee	0.67	0.67			0.67	
	....	....			....	
Admin Cost	302,678	297,448	98.3%	(5,230)	10,750	-48.6%
Cost by Deductible						
$0.00	7,274,659	7,693,577	105.8%	418,918	692,164	60.5%
$1.00	6,822,901	7,249,625	106.3%	426,724	676,119	63.1%
$2.00	6,371,143	6,805,673	106.8%	434,530	660,074	65.8%
$3.00	5,919,385	6,361,721	107.5%	442,336	644,029	68.7%
$4.00	5,467,627	5,917,769	108.2%	450,141	627,984	71.7%
$5.00	5,015,870	5,473,817	109.1%	457,947	611,939	74.8%
TOTAL MDO:Charges	23,999,227	25,198,953	105.0%	1,199,726	2,028,711	59.1%
* Prescriptions	1,635,874	1,610,183	98.4%	(25,691)	41,557	-61.8%
Admin Fee	0.67	0.67			0.67	
	....	....			....	
Admin Cost	1,096,036	1,078,823	98.4%	(17,213)	27,843	-61.8%
Cost by Deductible						
$0.00	25,095,263	26,277,776	104.7%	1,182,513	2,056,554	57.5%
$1.00	23,459,389	24,667,593	105.2%	1,208,204	2,014,997	60.0%
$2.00	21,823,514	23,057,410	105.7%	1,233,895	1,973,440	62.5%
$3.00	20,187,640	21,447,227	106.2%	1,259,587	1,931,883	65.2%
$4.00	18,551,766	19,837,044	106.9%	1,285,278	1,890,326	68.0%
$5.00	16,915,892	18,226,861	107.7%	1,310,969	1,848,769	70.9%

* Expected Prescriptions Projected by Adjusting Mail Order Claims to Retail Limits

TABLE 6: MDO EXPERIENCE BY OPTION DATE

	OPTION YEAR	STUDY YEAR	PERCENT MAIL ORDER	[RATIO OF ACTUAL TO EXPECTED COST]			UNITS PER PATIENT RATIO	DAYS PER PATIENT RATIO	PERCENT OF ALL MDO CHARGES
				BY UNITS	BY DAYS	BY PATIENTS			
Under 65:	Pre-1983	83-84	7.2%	96.3%	95.2%	106.4%	110.5%	111.8%	
	Pre-1983	84-85	7.4%	96.6%	95.5%	106.0%	109.8%	111.0%	60.7%
	1983	84-85	7.9%	94.3%	96.5%	102.5%	108.7%	112.6%	39.3%
	Total	84-85	7.6%	95.7%	95.9%	104.6%	109.2%	109.0%	
Over 65:	Pre-1983	83-84	7.7%	97.5%	96.8%	107.6%	110.4%	111.2%	
	Pre-1983	84-85	8.3%	97.7%	96.8%	107.2%	109.7%	110.8%	68.2%
	1983	84-85	11.2%	96.1%	94.6%	103.8%	108.0%	114.1%	31.8%
	Total	84-85	9.2%	97.2%	96.1%	106.1%	109.2%	110.3%	
All MDO:	Pre-1983	83-84	7.4%	96.7%	95.7%	106.8%	110.4%	115.4%	
	Pre-1983	84-85	7.7%	96.9%	95.9%	106.4%	109.7%	114.4%	62.9%
	1983	84-85	8.7%	94.8%	96.0%	102.8%	108.5%	113.0%	37.1%
	Total	84-85	8.1%	96.1%	96.0%	105.0%	109.3%	113.9%	

EXHIBIT 1: COMPARISON OF CLAIMANT DEMOGRAPHIC DATA

UNDER 65 POPULATION

Average Age	MDO GROUP	CONTROL GROUP 1	CONTROL GROUP 2	1985 PCS
Male Cardholder	50.9	49.9	48.2	48.0
Male Spouse	50.5	49.9	48.7	48.8
All Males	50.9	49.9	48.3	48.1
Female Cardholder	49.4	46.0	44.5	44.0
Female Spouse	49.2	48.7	46.6	46.5
All Females	49.2	47.8	45.7	45.1
All Claimants	50.0	48.7	46.8	46.4

Percent Female	MDO GROUP	CONTROL GROUP 1	CONTROL GROUP 2	1985 PCS
Cardholders	31.7%	33.0%	44.0%	46.6%
Spouses	88.7%	88.6%	80.3%	80.3%
All Claimants	56.1%	56.4%	58.5%	57.4%

Percent Cardholders	MDO GROUP	CONTROL GROUP 1	CONTROL GROUP 2	1985 PCS
Cardholders	57.2%	57.9%	60.0%	68.0%
Spouses	42.8%	42.1%	40.0%	32.0%

65 AND OVER POPULATION

Average Age	MDO GROUP	CONTROL GROUP 1	CONTROL GROUP 2	1985 PCS
Male Cardholder	73.6	73.5	73.6	73.2
Male Spouse	72.4	72.2	71.8	72.1
All Males	73.5	73.4	73.3	73.1
Female Cardholder	74.1	74.5	74.9	74.2
Female Spouse	72.4	72.5	72.5	72.6
All Females	73.2	73.4	73.8	73.5
All Claimants	73.4	73.4	73.6	73.3

Percent Female	MDO GROUP	CONTROL GROUP 1	CONTROL GROUP 2	1985 PCS
Cardholders	33.1%	33.8%	41.9%	40.0%
Spouses	88.0%	87.2%	79.2%	81.5%
All Claimants	48.6%	50.8%	53.0%	51.6%

Percent Cardholders	MDO GROUP	CONTROL GROUP 1	CONTROL GROUP 2	1985 PCS
Cardholders	71.8%	68.1%	70.1%	72.0%
Spouses	28.2%	31.9%	29.9%	28.0%

EXHIBIT 2: USC CLASSES AND RANKS BY CHARGES

USC CODE	CLASSIFICATION NAME	UNDER 65 RANK		OVER 65 RANK	
		CG1	MDO	CG1	MDO
12	Trichomonacides	46	45	70	70
21	Analgesics, non-narcotic	10	10	16	15
22	Analgesics, narcotic	13	14	18	18
51	Antacids	x	x	133	122
91	Antiarthritics, systemic	1	1	1	1
93	Gout-specific preparations	31	26	20	19
111	Anticoagulants, oral	56	58	43	40
120	Anticonvulsants	35	31	37	35
131	Antidiarrheals, w/o antnfctve	45	44	38	39
141	Antihistamines, caps & tabs	38	42	40	44
151	Antibiotics, broad & medium	2	2	8	9
152	Penicillins	26	25	44	47
153	Sulfonamides, systemic	47	49	61	56
154	Urinary antibacterials	42	40	34	34
155	Trimethoprim	30	30	31	29
160	Antimalarials	71	67	69	68
170	Antinauseants	44	41	28	30
181	Anti-obesity, Schedule II	68	72	x	x
182	Anti-obesity, other preps.	28	32	60	58
201	Anti-parkinsonism, L-Dopa	61	60	27	25
202	Anti-parkinsonism, other	62	61	49	46
231	Antispasm., synthetic	52	52	45	45
232	Antispasm., belladonna	48	48	46	48
233	Antispasm., w/tranquilizers	34	28	36	37
234	Antispasm/antisecr., other	5	5	7	6
235	Urinary tract antispasmodics	79	77	58	52
236	Pro-motility agents	51	47	42	41
281	General Bronchodilators	14	12	12	10
282	Chromolyn and similars	58	62	72	73
283	Bronchial Mucolytics	95	86	x	x
301	Anti-Leukemia Drugs	69	66	67	72
302	Other cytostatic drugs	43	36	29	28
303	Immunosuppressive drugs	63	56	x	x
311	Antihypertensive drugs	7	7	4	3
312	Vasodilators	9	8	2	2
313	Anti-arrhythmia agents	24	22	11	12
314	Beta-blocking agents	3	3	5	5
315	Digitalis preparations	55	54	25	26
317	Calcium channel blockers	16	15	9	8
321	Chlolesterol reducers	41	37	32	33
341	Oral cold preparations	12	13	26	27
343	Cough/cold preparations	32	34	39	43
344	Preps-cough only	39	38	41	42
371	Acne therapy	49	55	x	x
372	Anti-infectives, topical	72	74	64	64
373	Antipruritics	73	70	62	63
374	Fungicides	18	20	35	38
376	Anti-dandruff preparations	75	76	80	80
378	Dermatologicals, Other	80	81	x	x
391	Diabetes therapy, insulin	21	19	17	17

EXHIBIT 2: USC CLASSES AND RANKS BY CHARGES

USC CODE	CLASSIFICATION NAME	UNDER 65 RANK		OVER 65 RANK	
		CG1	MDO	CG1	MDO
392	Diabetes therapy, oral	19	17	10	11
393	Insulin/syringe combination	60	59	48	71
412	Diuretics, non-injectable	6	6	3	4
431	Enzymes, topical	x	x	77	76
435	Enzymes, fibrinolytic	x	x	76	74
450	Feminine hygiene preparations	x	x	130	113
481	Hematinics, ferrous	53	53	47	49
483	Hematinics, vitamin B12	x	x	73	75
484	Hematinics, other	x	x	81	84
492	Hemorrhoidal preps. w/cort.	50	51	53	57
521	Sex hormones	11	11	21	22
522	Corticoids, plain	8	9	13	14
523	Corticoids in combinations	25	24	33	31
524	Anabolic Hormones	84	94	x	x
526	Mineralocorticoids	105	100	91	82
528	Hormones, other	74	79	74	66
563	Bulk Producing Laxatives	89	82	65	67
591	Muscle relaxants, non-surgical	15	18	23	23
601	Potassium supplements	22	21	14	13
602	Supplements: Fluorides	83	80	85	85
607	Nutrients & supplements, other	x	x	108	100
611	Ophth: mydriatics	x	x	112	101
613	Ophth: decongestants	x	x	68	69
614	Ophth: Miotics & Glaucoma	36	35	15	16
616	Ophth: Anti-infectives	54	57	51	53
617	Ophth: other	x	x	123	107
630	Parasympathetic drugs	70	69	56	51
641	Tranquilizers	4	4	6	7
642	Psychostimulants	23	23	24	24
643	Psychostimulant tranquilizers	17	16	19	20
644	Lithium products	67	71	84	83
671	Barbiturate sedatives	64	65	54	54
672	Non-barbiturate sedatives	33	33	22	21
690	Proprietary Smoking Deterant	29	29	59	60
721	Thyroid hormone	27	27	30	32
723	Systemic iodine preparations	77	73	63	65
740	Tuberculosis therapy	x	x	75	62
761	Multivitamins	37	39	66	61
762	B-complex vitamins	59	63	55	59
763	Other ethical vitamins	x	x	78	78
781	Crude Drugs & Chemicals	114	104	101	96
782	Scabicides & pediculocides	78	75	x	x
783	Specific antagonists	66	64	71	77
784	Digestants, ethical	65	68	57	55
788	All other misc. ethical drugs	40	43	52	50
820	Needles and syringes	57	46	50	36

EXHIBIT 3: STUDY GROUP CLAIM SUMMARIES

UNDER AGE 65:

	MDO GROUP	PRE 1983 MDO OPTION	CONTROL GROUP 1	CONTROL GROUP 2
CHARGES	$17,802,824	$10,810,668	$27,717,379	$35,126,727
PRESCRIPTIONS	1,166,231	696,496	1,879,754	2,421,784
UNITS	70,404,276	42,240,064	105,566,720	132,516,317
DAYS	29,357,403	17,770,781	43,556,649	54,350,474
PATIENTS	421,719	247,584	704,377	931,658

AGE 65 AND OVER:

	MDO GROUP	PRE 1983 MDO OPTION	CONTROL GROUP 1	CONTROL GROUP 2
CHARGES	$7,387,504	$5,037,642	$10,190,064	$7,182,842
PRESCRIPTIONS	443,952	301,594	630,647	454,239
UNITS	31,242,809	21,193,860	42,309,668	29,065,504
DAYS	13,900,120	9,362,152	18,437,046	12,806,256
PATIENTS	115,819	77,700	169,899	109,698

ALL AGES:

CHARGES	$25,190,328	$15,848,310	$37,907,443	$42,309,569
PRESCRIPTIONS	1,610,183	998,090	2,510,401	2,876,023
UNITS	101,647,085	63,433,924	147,876,388	161,581,821
DAYS	43,257,523	27,132,933	61,993,695	67,156,730
PATIENTS	537,538	325,284	874,276	1,041,356

The MDO Group includes plans whose mail order option was effective on or before January 1, 1984.

The Pre-1983 MDO Option Group is the subset of the MDO Group with mail order options in effect on or before January 1, 1983.

EXHIBIT 4: CONTROL GROUP 1 UNDER 65 CLAIM DATA

USC CODE	CHARGES	CLAIMS	UNITS	DAYS OF FILL	PATIENT COUNT	PERCENT OF TOTAL CHARGES	CUMULATIVE % CHARGES
91	2,354,775	100,767	4,999,571	2,058,922	39,640	8.50%	8.5%
151	2,344,996	169,576	5,644,222	1,653,016	85,287	8.46%	17.0%
314	1,986,525	103,911	7,104,854	3,729,726	21,308	7.17%	24.1%
641	1,775,865	109,918	6,276,809	2,411,899	30,502	6.41%	30.5%
234	1,510,189	46,056	3,378,171	1,130,067	15,118	5.45%	36.0%
412	1,507,936	145,538	7,483,658	5,826,156	35,168	5.44%	41.4%
311	1,283,714	67,548	4,949,418	2,353,315	13,072	4.63%	46.1%
522	970,072	75,944	3,342,937	1,065,286	32,849	3.50%	49.6%
312	893,940	48,539	4,137,979	1,435,782	9,525	3.23%	52.8%
21	825,378	63,885	2,861,835	784,972	24,871	2.98%	55.8%
521	773,579	55,827	2,594,258	2,051,939	17,044	2.79%	58.5%
341	731,589	70,256	3,186,655	1,121,657	33,470	2.64%	61.2%
22	664,418	85,905	2,790,602	668,225	42,377	2.40%	63.6%
281	598,171	46,242	3,136,339	1,020,921	9,467	2.16%	65.7%
591	520,426	31,759	1,442,403	429,247	16,155	1.88%	67.6%
317	505,956	17,680	1,790,795	506,327	3,673	1.83%	69.4%
643	497,074	30,551	1,807,284	853,537	7,579	1.79%	71.2%
374	493,153	35,557	1,381,806	413,884	19,073	1.78%	73.0%
392	472,160	21,704	1,455,443	829,729	4,399	1.70%	74.7%
391	442,085	21,004	349,302	475,090	3,014	1.59%	76.3%
601	403,966	35,612	3,837,175	1,152,449	8,660	1.46%	77.8%
642	324,914	16,857	1,029,007	463,099	4,415	1.17%	78.9%
313	308,471	10,736	1,107,625	308,045	2,023	1.11%	80.1%
523	257,099	22,853	439,782	235,182	15,635	0.93%	81.0%
152	248,556	34,852	1,145,266	289,008	24,291	0.90%	81.9%
721	244,566	33,603	2,416,618	1,797,481	9,177	0.88%	82.8%
182	222,651	16,924	594,871	486,165	5,750	0.80%	83.6%
690	212,367	12,118	1,196,157	175,571	6,182	0.77%	84.3%
155	211,828	16,856	500,157	221,019	11,536	0.76%	85.1%
93	210,055	16,299	940,181	655,449	3,986	0.76%	85.9%
343	195,884	23,767	3,099,382	221,529	15,572	0.71%	86.6%
672	194,402	20,066	639,954	542,398	6,827	0.70%	87.3%
233	188,545	10,593	634,729	211,124	4,557	0.68%	87.9%
120	187,741	13,098	1,430,383	403,144	2,288	0.68%	88.6%
614	181,937	10,392	183,263	198,593	1,899	0.66%	89.3%
761	178,910	18,909	1,221,558	1,060,105	8,586	0.65%	89.9%
141	169,136	18,812	799,589	313,413	10,154	0.61%	90.5%
344	167,788	20,497	3,080,130	172,225	13,561	0.61%	91.1%
788	166,136	5,240	367,354	89,733	2,599	0.60%	91.7%
321	156,136	5,797	617,903	177,370	1,213	0.56%	92.3%
154	154,361	12,265	482,158	161,625	7,190	0.56%	92.9%
302	136,443	3,046	186,665	63,887	752	0.49%	93.3%
170	131,414	12,325	417,341	145,314	7,440	0.47%	93.8%
131	119,114	10,302	515,290	110,200	6,421	0.43%	94.3%
12	115,140	7,141	326,811	58,337	5,634	0.42%	94.7%
153	97,699	6,386	615,233	111,697	3,454	0.35%	95.0%
232	90,657	10,429	740,205	205,643	5,026	0.33%	95.3%
371	87,799	7,877	454,585	127,986	3,791	0.32%	95.7%
492	86,558	7,306	151,923	66,894	3,979	0.31%	96.0%
236	85,504	4,321	323,775	91,336	1,933	0.31%	96.3%

EXHIBIT 4: CONTROL GROUP 1 UNDER 65 CLAIM DATA

USC CODE	CHARGES	CLAIMS	UNITS.	DAYS OF FILL	PATIENT COUNT	PERCENT OF TOTAL CHARGES	CUMULATIVE % CHARGES
231	76,466	6,975	466,960	129,734	3,238	0.28%	96.6%
481	73,554	5,281	282,334	208,844	2,277	0.27%	96.8%
616	64,105	7,557	66,781	75,563	5,919	0.23%	97.1%
315	57,394	12,129	734,007	624,918	3,424	0.21%	97.3%
111	46,593	4,276	250,311	157,420	1,093	0.17%	97.4%
820	43,595	2,324	152,009	79,018	547	0.16%	97.6%
282	40,950	2,550	114,717	42,435	1,020	0.15%	97.7%
762	40,592	3,744	206,723	162,207	1,443	0.15%	97.9%
393	38,810	1,039	67,239	32,349	202	0.14%	98.0%
201	36,521	982	104,135	27,800	193	0.13%	98.2%
202	34,881	3,497	174,307	76,682	1,526	0.13%	98.3%
303	34,544	610	47,866	19,357	131	0.12%	98.4%
671	34,374	6,106	605,418	183,338	1,659	0.12%	98.5%
784	33,183	2,148	238,600	47,841	676	0.12%	98.7%
783	29,700	1,092	54,713	35,093	352	0.11%	98.8%
644	28,058	3,098	295,180	89,172	598	0.10%	98.9%
181	27,457	1,784	74,539	53,567	482	0.10%	99.0%
301	27,285	906	23,377	12,863	199	0.10%	99.1%
630	25,528	1,173	91,775	26,356	387	0.09%	99.1%
160	25,357	1,176	59,777	41,460	464	0.09%	99.2%
372	25,120	2,800	103,552	31,742	1,998	0.09%	99.3%
373	24,692	2,211	123,734	36,004	1,231	0.09%	99.4%
528	23,360	531	20,322	12,667	112	0.08%	99.5%
376	22,668	2,661	315,526	43,715	1,337	0.08%	99.6%
723	19,986	2,045	227,493	25,087	1,226	0.07%	99.7%
782	18,111	1,592	237,239	12,984	1,234	0.07%	99.7%
235	17,747	1,267	67,633	24,075	618	0.06%	99.8%
378	16,185	1,763	52,510	24,589	1,232	0.06%	99.8%
602	13,365	1,677	439,513	53,243	1,059	0.05%	99.9%
524	12,906	532	37,286	12,678	96	0.05%	99.9%
563	6,736	296	172,485	5,494	105	0.02%	100.0%
283	5,003	102	5,924	1,088	20	0.02%	100.0%
526	3,315	235	13,785	8,420	68	0.01%	100.0%
781	1,460	149	29,539	3,128	89	0.01%	100.0%
998	27,717,379	1,879,754	105,566,720	43,556,649	704,377		
999	27,899,778	1,897,105			715,091		
900	99.35%	99.09%	N.A.	N.A.	98.50%		

998 Sample Totals
999 Total All USC Classes
900 Ratio of Sample (998) to Total (999)

EXHIBIT 5: CONTROL GROUP 1 OVER 65 CLAIM DATA

USC CODE	CHARGES	CLAIMS	UNITS	DAYS OF FILL	PATIENT COUNT	PERCENT OF TOTAL CHARGES	CUMULATIVE % CHARGES
91	1,047,409	36,883	2,237,960	960,274	9,867	10.27%	10.3%
312	1,018,380	56,195	4,811,420	1,700,379	8,822	9.98%	20.3%
412	749,743	69,683	3,881,126	2,914,694	15,389	7.35%	27.6%
311	744,255	39,463	2,953,287	1,416,846	7,362	7.30%	34.9%
314	670,011	36,632	2,813,371	1,297,238	7,181	6.57%	41.5%
641	488,447	30,496	1,909,585	757,859	7,650	4.79%	46.3%
234	483,720	14,488	1,075,910	391,569	4,111	4.74%	51.0%
151	343,482	23,287	746,244	224,476	11,642	3.37%	54.4%
317	326,875	11,663	1,180,203	342,185	2,248	3.20%	57.6%
392	308,793	14,279	986,553	563,486	2,770	3.03%	60.6%
313	306,142	11,207	1,119,184	324,212	1,986	3.00%	63.6%
281	284,215	20,934	1,605,024	523,104	3,147	2.79%	66.4%
522	262,894	21,244	954,854	366,981	7,528	2.58%	69.0%
601	257,669	23,131	2,890,444	768,958	5,136	2.53%	71.5%
614	226,630	13,109	225,382	271,777	2,160	2.22%	73.7%
21	220,414	14,092	844,962	234,935	4,223	2.16%	75.9%
391	169,153	8,159	137,057	202,947	1,269	1.66%	77.5%
22	134,585	13,818	655,115	159,515	5,265	1.32%	78.8%
643	111,774	7,449	449,519	226,090	1,773	1.10%	79.9%
93	110,926	8,740	525,745	362,978	2,066	1.09%	81.0%
521	109,737	7,440	429,799	283,634	2,377	1.08%	82.1%
672	109,244	10,705	368,540	316,505	3,088	1.07%	83.2%
591	95,653	5,673	297,676	115,779	2,333	0.94%	84.1%
642	92,276	4,957	307,135	151,892	1,164	0.90%	85.0%
315	86,790	18,317	1,136,502	966,842	4,912	0.85%	85.9%
341	82,290	7,735	418,615	134,172	3,544	0.81%	86.7%
201	81,961	2,371	247,866	69,605	399	0.80%	87.5%
170	80,768	6,377	358,405	116,690	2,493	0.79%	88.3%
302	72,151	1,682	103,536	36,277	452	0.71%	89.0%
721	67,662	9,601	718,628	546,124	2,726	0.66%	89.6%
155	67,606	4,975	167,476	79,595	2,745	0.66%	90.3%
321	67,264	2,529	255,299	78,172	527	0.66%	91.0%
523	63,528	5,541	103,645	66,117	3,187	0.62%	91.6%
154	54,513	3,587	185,171	62,124	1,528	0.53%	92.1%
374	52,371	3,349	141,710	50,752	1,577	0.51%	92.6%
233	52,003	2,540	176,151	60,907	921	0.51%	93.1%
120	46,804	4,079	410,994	121,672	772	0.46%	93.6%
131	41,094	3,222	182,260	42,368	1,580	0.40%	94.0%
343	37,251	4,441	663,831	45,805	2,456	0.37%	94.4%
141	35,953	3,886	189,845	85,775	1,743	0.35%	94.7%
344	35,601	4,217	680,472	37,652	2,362	0.35%	95.1%
236	34,289	1,744	157,290	39,550	596	0.34%	95.4%
111	33,801	3,157	185,399	120,933	806	0.33%	95.7%
152	26,986	3,046	93,816	29,965	2,034	0.26%	96.0%
231	26,578	2,063	163,287	46,757	739	0.26%	96.3%
232	24,817	3,017	284,621	69,234	1,077	0.24%	96.5%
481	23,605	1,570	91,860	60,479	473	0.23%	96.7%
393	22,856	628	42,627	20,913	106	0.22%	97.0%
202	21,751	1,518	101,362	44,814	367	0.21%	97.2%
820	17,962	1,019	62,217	35,675	253	0.18%	97.3%

EXHIBIT 5: CONTROL GROUP 1 OVER 65 CLAIM DATA

USC CODE	CHARGES	CLAIMS	UNITS	DAYS OF FILL	PATIENT COUNT	PERCENT OF TOTAL CHARGES	CUMULATIVE % CHARGES
616	17,657	2,146	17,873	24,728	1,344	0.17%	97.5%
788	17,591	645	124,564	12,630	276	0.17%	97.7%
492	16,826	1,373	27,755	13,966	625	0.16%	97.9%
671	15,506	2,329	243,945	71,139	639	0.15%	98.0%
762	15,354	1,443	79,739	63,252	477	0.15%	98.2%
630	13,916	537	52,940	12,722	171	0.14%	98.3%
784	13,624	906	94,879	22,987	263	0.13%	98.4%
235	12,826	855	50,405	20,122	308	0.13%	98.6%
690	11,649	645	65,190	10,271	383	0.11%	98.7%
182	11,252	807	32,820	25,606	276	0.11%	98.8%
153	10,984	793	66,206	16,161	380	0.11%	98.9%
373	10,448	781	51,138	12,594	309	0.10%	99.0%
723	9,144	833	110,917	12,380	346	0.09%	99.1%
372	8,347	854	28,067	10,528	431	0.08%	99.2%
563	7,859	438	187,321	6,149	104	0.08%	99.2%
761	7,512	898	51,157	37,207	298	0.07%	99.3%
301	7,012	342	15,174	8,157	92	0.07%	99.4%
613	6,090	703	10,518	11,821	449	0.06%	99.4%
12	5,292	318	21,580	3,490	250	0.05%	99.5%
783	5,196	193	12,618	6,073	39	0.05%	99.5%
282	5,134	279	15,154	5,870	106	0.05%	99.6%
160	4,512	278	14,387	9,163	100	0.04%	99.6%
483	4,190	523	8,991	15,167	237	0.04%	99.7%
528	3,999	98	3,736	3,237	26	0.04%	99.7%
740	3,945	110	7,854	4,569	25	0.04%	99.8%
435	3,544	174	4,030	2,265	80	0.03%	99.8%
431	3,488	220	25,427	2,711	87	0.03%	99.8%
763	3,172	414	16,314	14,503	175	0.03%	99.9%
376	2,939	340	42,013	6,330	194	0.03%	99.9%
484	2,845	534	43,378	20,135	163	0.03%	99.9%
644	2,523	323	26,921	10,169	70	0.02%	99.9%
602	2,490	319	78,878	9,766	129	0.02%	100.0%
526	1,581	125	6,940	5,221	38	0.02%	100.0%
781	969	91	41,769	2,250	28	0.01%	100.0%
607	598	66	16,898	831	15	0.01%	100.0%
611	431	44	904	804	10	0.00%	100.0%
617	137	17	560	339	13	0.00%	100.0%
450	66	6	487	52	6	0.00%	100.0%
51	32	5	1,441	71	5	0.00%	100.0%
998	10,201,362	631,743	42,429,868	18,462,718	169,899		
999	10,241,884	634,975			171,621		
900	99.60%	99.49%	N.A.	N.A.	99.00%		

998 Sample Totals
999 Total All USC Classes
900 Ratio of Sample (998) to Total (999)

EXHIBIT 6: CONTROL GROUP 1 UNDER 65 CLAIM PARAMETERS

USC CODE	COST PER CLAIM	COST PER UNIT	COST PER DAY	COST PER PATIENT	CLAIMS PER PATIENT	UNITS PER PATIENT	DAYS PER PATIENT	DAYS PER CLAIM
91	23.37	0.47	1.14	59.40	2.54	126.12	51.94	20.43
151	13.83	0.42	1.42	27.50	1.99	66.18	19.38	9.75
314	19.12	0.28	0.53	93.23	4.88	333.44	175.04	35.89
641	16.16	0.28	0.74	58.22	3.60	205.78	79.07	21.94
234	32.79	0.45	1.34	99.89	3.05	223.45	74.75	24.54
412	10.36	0.20	0.26	42.80	4.14	212.80	165.67	40.03
311	19.00	0.26	0.55	98.20	5.17	378.63	180.03	34.84
522	12.77	0.29	0.91	29.53	2.31	101.77	32.43	14.03
312	18.42	0.22	0.62	93.85	5.10	434.43	150.74	29.58
21	12.92	0.29	1.05	33.19	2.57	115.07	31.56	12.29
521	13.86	0.30	0.38	45.39	3.28	152.21	120.39	36.76
341	10.41	0.23	0.65	21.86	2.10	95.21	33.51	15.97
22	7.73	0.24	0.99	15.68	2.03	65.85	15.77	7.78
281	12.94	0.19	0.59	63.18	4.88	331.29	107.84	22.08
591	16.39	0.36	1.21	32.21	1.97	89.29	26.57	13.52
317	28.62	0.28	1.00	137.75	4.81	487.56	137.85	28.64
643	16.27	0.28	0.58	65.59	4.03	238.46	112.62	27.94
374	13.87	0.36	1.19	25.86	1.86	72.45	21.70	11.64
392	21.75	0.32	0.57	107.33	4.93	330.86	188.62	38.23
391	21.05	1.27	0.93	146.68	6.97	115.89	157.63	22.62
601	11.34	0.11	0.35	46.65	4.11	443.09	133.08	32.36
642	19.27	0.32	0.70	73.59	3.82	233.07	104.89	27.47
313	28.73	0.28	1.00	152.48	5.31	547.52	152.27	28.69
523	11.25	0.58	1.09	16.44	1.46	28.13	15.04	10.29
152	7.13	0.22	0.86	10.23	1.43	47.15	11.90	8.29
721	7.28	0.10	0.14	26.65	3.66	263.33	195.87	53.49
182	13.16	0.37	0.46	38.72	2.94	103.46	84.55	28.73
690	17.52	0.18	1.21	34.35	1.96	193.49	28.40	14.49
155	12.57	0.42	0.96	18.36	1.46	43.36	19.16	13.11
93	12.89	0.22	0.32	52.70	4.09	235.87	164.44	40.21
343	8.24	0.06	0.88	12.58	1.53	199.04	14.23	9.32
672	9.69	0.30	0.36	28.48	2.94	93.74	79.45	27.03
233	17.80	0.30	0.89	41.37	2.32	139.29	46.33	19.93
120	14.33	0.13	0.47	82.05	5.72	625.17	176.20	30.78
614	17.51	0.99	0.92	95.81	5.47	96.51	104.58	19.11
761	9.46	0.15	0.17	20.84	2.20	142.27	123.47	56.06
141	8.99	0.21	0.54	16.66	1.85	78.75	30.87	16.66
344	8.19	0.05	0.97	12.37	1.51	227.13	12.70	8.40
788	31.71	0.45	1.85	63.92	2.02	141.34	34.53	17.12
321	26.93	0.25	0.88	128.72	4.78	509.40	146.22	30.60
154	12.59	0.32	0.96	21.47	1.71	67.06	22.48	13.18
302	44.79	0.73	2.14	181.44	4.05	248.22	84.96	20.97
170	10.66	0.31	0.90	17.66	1.66	56.09	19.53	11.79
131	11.56	0.23	1.08	18.55	1.60	80.25	17.16	10.70
12	16.12	0.35	1.97	20.44	1.27	58.01	10.35	8.17
153	15.30	0.16	0.87	28.29	1.85	178.12	32.34	17.49
232	8.69	0.12	0.44	18.04	2.08	147.28	40.92	19.72
371	11.15	0.19	0.69	23.16	2.08	119.91	33.76	16.25
492	11.85	0.57	1.29	21.75	1.84	38.18	16.81	9.16
236	19.79	0.26	0.94	44.23	2.24	167.50	47.25	21.14

EXHIBIT 6: CONTROL GROUP 1 UNDER 65 CLAIM PARAMETERS

USC CODE	COST PER CLAIM	COST PER UNIT	COST PER DAY	COST PER PATIENT	CLAIMS PER PATIENT	UNITS PER PATIENT	DAYS PER PATIENT	DAYS PER CLAIM
231	10.96	0.16	0.59	23.62	2.15	144.21	40.07	18.60
481	13.93	0.26	0.35	32.30	2.32	123.99	91.72	39.55
616	8.48	0.96	0.85	10.83	1.28	11.28	12.77	10.00
315	4.73	0.08	0.09	16.76	3.54	214.37	182.51	51.52
111	10.90	0.19	0.30	42.63	3.91	229.01	144.03	36.81
820	18.76	0.29	0.55	79.70	4.25	277.90	144.46	34.00
282	16.06	0.36	0.97	40.15	2.50	112.47	41.60	16.64
762	10.84	0.20	0.25	28.13	2.59	143.26	112.41	43.32
393	37.35	0.58	1.20	192.13	5.14	332.87	160.14	31.13
201	37.19	0.35	1.31	189.23	5.09	539.56	144.04	28.31
202	9.97	0.20	0.45	22.86	2.29	114.22	50.25	21.93
303	56.63	0.72	1.78	263.69	4.66	365.39	147.76	31.73
671	5.63	0.06	0.19	20.72	3.68	364.93	110.51	30.03
784	15.45	0.14	0.69	49.09	3.18	352.96	70.77	22.27
783	27.20	0.54	0.85	84.38	3.10	155.43	99.70	32.14
644	9.06	0.10	0.31	46.92	5.18	493.61	149.12	28.78
181	15.39	0.37	0.51	56.96	3.70	154.65	111.13	30.03
301	30.12	1.17	2.12	137.11	4.55	117.47	64.64	14.20
630	21.76	0.28	0.97	65.96	3.03	237.14	68.10	22.47
160	21.56	0.42	0.61	54.65	2.53	128.83	89.35	35.26
372	8.97	0.24	0.79	12.57	1.40	51.83	15.89	11.34
373	11.17	0.20	0.69	20.06	1.80	100.52	29.25	16.28
528	43.99	1.15	1.84	208.57	4.74	181.45	113.10	23.85
376	8.52	0.07	0.52	16.95	1.99	236.00	32.70	16.43
723	9.77	0.09	0.80	16.30	1.67	185.56	20.46	12.27
782	11.38	0.08	1.39	14.68	1.29	192.25	10.52	8.16
235	14.01	0.26	0.74	28.72	2.05	109.44	38.96	19.00
378	9.18	0.31	0.66	13.14	1.43	42.62	19.96	13.95
602	7.97	0.03	0.25	12.62	1.58	415.03	50.28	31.75
524	24.26	0.35	1.02	134.44	5.54	388.40	132.06	23.83
563	22.76	0.04	1.23	64.15	2.82	1642.71	52.32	18.56
283	49.05	0.84	4.60	250.15	5.10	296.20	54.40	10.67
526	14.11	0.24	0.39	48.75	3.46	202.72	123.82	35.83
781	9.80	0.05	0.47	16.40	1.67	331.90	35.15	20.99
998	14.75	0.26	0.64	39.35	2.67	149.87	61.84	23.17
999	14.71			39.02	2.65			

998 Parameters for Sample
999 Parameters for all USC Classes

EXHIBIT 7: CONTROL GROUP 1 OVER 65 CLAIM PARAMETERS

USC CODE	COST PER CLAIM	COST PER UNIT	COST PER DAY	COST PER PATIENT	CLAIMS PER PATIENT	UNITS PER PATIENT	DAYS PER PATIENT	DAYS PER CLAIM
91	28.40	0.47	1.09	106.15	3.74	226.81	97.32	26.04
312	18.12	0.21	0.60	115.44	6.37	545.39	192.74	30.26
412	10.76	0.19	0.26	48.72	4.53	252.20	189.40	41.83
311	18.86	0.25	0.53	101.09	5.36	401.15	192.45	35.90
314	18.29	0.24	0.52	93.30	5.10	391.78	180.65	35.41
641	16.02	0.26	0.64	63.85	3.99	249.62	99.07	24.85
234	33.39	0.45	1.24	117.66	3.52	261.71	95.25	27.03
151	14.75	0.46	1.53	29.50	2.00	64.10	19.28	9.64
317	28.03	0.28	0.96	145.41	5.19	525.00	152.22	29.34
392	21.63	0.31	0.55	111.48	5.15	356.16	203.42	39.46
313	27.32	0.27	0.94	154.15	5.64	563.54	163.25	28.93
281	13.58	0.18	0.54	90.31	6.65	510.02	166.22	24.99
522	12.37	0.28	0.72	34.92	2.82	126.84	48.75	17.27
601	11.14	0.09	0.34	50.17	4.50	562.78	149.72	33.24
614	17.29	1.01	0.83	104.92	6.07	104.34	125.82	20.73
21	15.64	0.26	0.94	52.19	3.34	200.09	55.63	16.67
391	20.73	1.23	0.83	133.30	6.43	108.00	159.93	24.87
22	9.74	0.21	0.84	25.56	2.62	124.43	30.30	11.54
643	15.01	0.25	0.49	63.04	4.20	253.54	127.52	30.35
93	12.69	0.21	0.31	53.69	4.23	254.47	175.69	41.53
521	14.75	0.26	0.39	46.17	3.13	180.82	119.32	38.12
672	10.20	0.30	0.35	35.38	3.47	119.35	102.50	29.57
591	16.86	0.32	0.83	41.00	2.43	127.59	49.63	20.41
642	18.62	0.30	0.61	79.27	4.26	263.86	130.49	30.64
315	4.74	0.08	0.09	17.67	3.73	231.37	196.83	52.78
341	10.64	0.20	0.61	23.22	2.18	118.12	37.86	17.35
201	34.57	0.33	1.18	205.42	5.94	621.22	174.45	29.36
170	12.67	0.23	0.69	32.40	2.56	143.76	46.81	18.30
302	42.90	0.70	1.99	159.63	3.72	229.06	80.26	21.57
721	7.05	0.09	0.12	24.82	3.52	263.62	200.34	56.88
155	13.59	0.40	0.85	24.63	1.81	61.01	29.00	16.00
321	26.60	0.26	0.86	127.64	4.80	484.44	148.33	30.91
523	11.47	0.61	0.96	19.93	1.74	32.52	20.75	11.93
154	15.20	0.29	0.88	35.68	2.35	121.19	40.66	17.32
374	15.64	0.37	1.03	33.21	2.12	89.86	32.18	15.15
233	20.47	0.30	0.85	56.46	2.76	191.26	66.13	23.98
120	11.47	0.11	0.38	60.63	5.28	532.38	157.61	29.83
131	12.75	0.23	0.97	26.01	2.04	115.35	26.82	13.15
343	8.39	0.06	0.81	15.17	1.81	270.29	18.65	10.31
141	9.25	0.19	0.42	20.63	2.23	108.92	49.21	22.07
344	8.44	0.05	0.95	15.07	1.79	288.09	15.94	8.93
236	19.66	0.22	0.87	57.53	2.93	263.91	66.36	22.68
111	10.71	0.18	0.28	41.94	3.92	230.02	150.04	38.31
152	8.86	0.29	0.90	13.27	1.50	46.12	14.73	9.84
231	12.88	0.16	0.57	35.96	2.79	220.96	63.27	22.66
232	8.23	0.09	0.36	23.04	2.80	264.27	64.28	22.95
481	15.04	0.26	0.39	49.90	3.32	194.21	127.86	38.52
393	36.39	0.54	1.09	215.62	5.92	402.14	197.29	33.30
202	14.33	0.21	0.49	59.27	4.14	276.19	122.11	29.52
820	17.63	0.29	0.50	71.00	4.03	245.92	141.01	35.01

EXHIBIT 7: CONTROL GROUP 1 OVER 65 CLAIM PARAMETERS

USC CODE	COST PER CLAIM	COST PER UNIT	COST PER DAY	COST PER PATIENT	CLAIMS PER PATIENT	UNITS PER PATIENT	DAYS PER PATIENT	DAYS PER CLAIM
616	8.23	0.99	0.71	13.14	1.60	13.30	18.40	11.52
788	27.27	0.14	1.39	63.74	2.34	451.32	45.76	19.58
492	12.25	0.61	1.20	26.92	2.20	44.41	22.35	10.17
671	6.66	0.06	0.22	24.27	3.64	381.76	111.33	30.54
762	10.64	0.19	0.24	32.19	3.03	167.17	132.60	43.83
630	25.91	0.26	1.09	81.38	3.14	309.59	74.40	23.69
784	15.04	0.14	0.59	51.80	3.44	360.76	87.40	25.37
235	15.00	0.25	0.64	41.64	2.78	163.65	65.33	23.53
690	18.06	0.18	1.13	30.42	1.68	170.21	26.82	15.92
182	13.94	0.34	0.44	40.77	2.92	118.91	92.78	31.73
153	13.85	0.17	0.68	28.91	2.09	174.23	42.53	20.38
373	13.38	0.20	0.83	33.81	2.53	165.50	40.76	16.13
723	10.98	0.08	0.74	26.43	2.41	320.57	35.78	14.86
372	9.77	0.30	0.79	19.37	1.98	65.12	24.43	12.33
563	17.94	0.04	1.28	75.57	4.21	1801.16	59.13	14.04
761	8.37	0.15	0.20	25.21	3.01	171.67	124.86	41.43
301	20.50	0.46	0.86	76.22	3.72	164.93	88.66	23.85
613	8.66	0.58	0.52	13.56	1.57	23.43	26.33	16.82
12	16.64	0.25	1.52	21.17	1.27	86.32	13.96	10.97
783	26.92	0.41	0.86	133.23	4.95	323.54	155.72	31.47
282	18.40	0.34	0.87	48.43	2.63	142.96	55.38	21.04
160	16.23	0.31	0.49	45.12	2.78	143.87	91.63	32.96
483	8.01	0.47	0.28	17.68	2.21	37.94	64.00	29.00
528	40.81	1.07	1.24	153.81	3.77	143.69	124.50	33.03
740	35.86	0.50	0.86	157.80	4.40	314.16	182.76	41.54
435	20.37	0.88	1.56	44.30	2.18	50.38	28.31	13.02
431	15.85	0.14	1.29	40.09	2.53	292.26	31.16	12.32
763	7.66	0.19	0.22	18.13	2.37	93.22	82.87	35.03
376	8.64	0.07	0.46	15.15	1.75	216.56	32.63	18.62
484	5.33	0.07	0.14	17.45	3.28	266.12	123.53	37.71
644	7.81	0.09	0.25	36.04	4.61	384.59	145.27	31.48
602	7.81	0.03	0.25	19.30	2.47	611.46	75.71	30.61
526	12.65	0.23	0.30	41.61	3.29	182.63	137.39	41.77
781	10.65	0.02	0.43	34.61	3.25	1491.75	80.36	24.73
607	9.06	0.04	0.72	39.87	4.40	1126.53	55.40	12.59
611	9.80	0.48	0.54	43.10	4.40	90.40	80.40	18.27
617	8.06	0.24	0.40	10.54	1.31	43.08	26.08	19.94
450	11.00	0.14	1.27	11.00	1.00	81.17	8.67	8.67
51	6.40	0.02	0.45	6.40	1.00	288.20	14.20	14.20
998	16.16	0.24	0.55	59.98	3.71	249.03	108.52	29.24
999	16.13			59.68	3.70			

998 Parameters for Sample
999 Parameters for all USC Classes

EXHIBIT 8: MDO UNDER 65 CLAIM DATA

USC CODE	CHARGES	CLAIMS	UNITS	DAYS OF FILL	PATIENT COUNT	MAIL ORDER CHARGES	MAIL ORDER PERCENT
91	1,626,742	65,854	3,554,865	1,469,692	25,116	164,951	10.1%
151	1,399,634	103,144	3,526,232	1,019,396	50,435	5,989	0.4%
314	1,322,652	65,061	4,936,206	2,597,047	13,266	179,729	13.6%
641	1,162,732	72,061	4,271,047	1,642,233	18,726	36,401	3.1%
234	1,049,903	31,387	2,392,256	806,729	9,841	79,114	7.5%
412	1,012,374	93,575	5,368,383	4,143,836	22,210	104,707	10.3%
311	869,813	42,705	3,503,062	1,671,852	8,384	118,681	13.6%
312	597,390	29,765	2,916,709	1,015,778	6,004	85,389	14.3%
522	560,961	43,994	2,042,352	658,461	19,076	20,828	3.7%
21	559,631	42,699	2,033,515	531,854	15,339	18,651	3.3%
521	450,042	33,065	1,595,268	1,273,744	9,721	22,717	5.0%
281	412,655	30,333	2,244,437	748,744	5,960	46,149	11.2%
341	403,075	39,842	1,852,866	638,491	18,769	15,489	3.8%
22	380,716	50,503	1,729,376	397,110	23,592	2,099	0.6%
317	376,771	11,636	1,368,023	384,971	2,502	64,477	17.1%
643	330,862	20,810	1,267,573	596,948	4,972	13,034	3.9%
392	321,315	13,893	1,020,221	586,152	2,779	39,415	12.3%
591	315,920	19,276	925,048	268,746	9,552	11,048	3.5%
391	288,570	12,790	253,932	363,462	2,002	42,309	14.7%
374	269,115	19,623	773,551	233,148	10,464	5,273	2.0%
601	257,598	21,587	2,466,030	801,860	5,268	37,107	14.4%
313	226,440	6,922	843,687	232,817	1,363	39,595	17.5%
642	223,827	11,646	720,470	331,403	2,979	10,851	4.8%
523	143,596	13,167	247,969	124,638	9,089	1,367	1.0%
152	139,306	20,388	692,257	174,707	14,220	429	0.3%
93	138,255	9,979	655,098	465,625	2,493	20,088	14.5%
721	137,807	19,123	1,472,747	1,105,688	5,109	11,467	8.3%
233	135,174	7,356	455,832	149,766	2,923	8,013	5.9%
690	133,902	7,810	764,115	109,358	3,923	433	0.3%
155	132,220	10,534	362,093	150,012	7,065	2,054	1.6%
120	129,070	8,866	1,049,106	302,248	1,531	16,118	12.5%
182	127,777	9,671	362,367	279,146	3,098	544	0.4%
672	123,814	13,179	409,855	356,806	4,068	3,014	2.4%
343	119,878	15,387	1,921,514	138,632	9,583	735	0.6%
614	109,353	5,990	111,776	123,005	1,165	9,295	8.5%
302	108,639	2,005	129,512	42,236	477	6,220	5.7%
321	108,213	3,582	430,982	122,704	755	16,362	15.1%
344	96,054	12,299	1,855,269	93,278	8,123	76	0.1%
761	91,739	10,147	642,996	560,630	4,486	1,605	1.7%
154	91,614	7,442	312,178	103,552	4,135	2,779	3.0%
170	82,764	7,899	297,945	99,455	4,503	2,142	2.6%
141	81,136	9,940	423,271	163,200	5,409	2,132	2.6%
788	77,152	2,590	169,909	44,038	1,382	1,253	1.6%
131	74,147	6,358	321,307	69,614	3,843	2,949	4.0%
12	61,630	3,759	176,276	32,658	3,001	1,019	1.7%
820	60,766	3,174	245,133	139,631	788	7,201	11.9%
236	59,198	2,882	236,492	65,735	1,191	4,222	7.1%
232	57,053	6,534	499,585	135,655	3,009	2,498	4.4%
153	56,425	3,724	382,935	71,780	1,986	5,048	8.9%
492	51,315	4,416	95,545	39,484	2,391	544	1.1%

EXHIBIT 8: MDO UNDER 65 CLAIM DATA

USC CODE	CHARGES	CLAIMS	UNITS	DAYS OF FILL	PATIENT COUNT	MAIL ORDER CHARGES	MAIL ORDER PERCENT
231	48,369	4,405	302,392	85,418	2,049	1,431	3.0%
481	43,171	3,173	170,815	124,499	1,295	1,793	4.2%
315	42,888	9,316	634,331	549,000	2,717	5,313	12.4%
371	41,436	3,784	232,883	60,950	1,809	581	1.4%
303	37,468	347	36,260	11,765	69	14,123	37.7%
616	37,031	4,519	40,771	39,223	3,491	117	0.3%
111	36,216	3,318	203,095	136,383	854	4,339	12.0%
393	28,405	769	57,767	29,081	146	2,275	8.0%
201	25,458	639	75,631	21,449	129	3,756	14.8%
202	22,881	2,308	113,538	54,401	983	1,128	4.9%
282	22,619	1,371	61,863	21,848	575	2,370	10.5%
762	19,103	1,781	103,489	81,482	660	1,547	8.1%
783	18,914	666	39,022	21,297	197	1,752	9.3%
671	17,838	3,399	318,345	104,572	1,009	712	4.0%
301	17,564	622	22,288	12,987	149	670	3.8%
160	16,662	748	43,417	28,626	242	1,803	10.8%
784	16,415	991	112,183	21,577	333	725	4.4%
630	16,315	646	57,110	15,769	222	1,164	7.1%
373	15,611	1,380	86,701	21,763	794	529	3.4%
644	15,230	1,722	168,715	50,457	313	767	5.0%
181	13,917	901	44,603	28,444	216	39	0.3%
723	13,639	1,393	147,412	18,581	809	727	5.3%
372	12,997	1,505	53,915	15,073	1,062	96	0.7%
782	12,045	1,096	164,679	7,944	853	0	0.0%
376	11,873	1,439	176,190	21,643	738	165	1.4%
235	11,110	767	45,578	15,989	354	315	2.8%
528	8,435	203	9,128	6,108	54	1,042	12.4%
602	7,561	1,022	260,674	38,962	660	70	0.9%
378	7,349	821	26,212	11,233	622	194	2.6%
563	6,809	334	172,246	4,773	83	734	10.8%
283	3,920	38	4,666	1,356	11	2,365	60.3%
524	2,926	138	9,622	4,634	45	349	11.9%
526	2,291	177	10,510	7,667	47	428	18.7%
781	1,623	121	69,052	4,694	63	268	16.5%
998	17,802,824	1,166,231	70,404,276	29,357,403	421,719	1,347,297	7.6%
999	17,887,177	1,175,167			427,458	1,348,904	7.5%
900	99.53%	99.24%	N.A.	N.A.	98.66%		

998 Sample Totals
999 Total All USC Classes
900 Ratio of Sample (998) to Total (999)

EXHIBIT 9: MDO OVER 65 CLAIM DATA

USC CODE	CHARGES	CLAIMS	UNITS	DAYS OF FILL	PATIENT COUNT	MAIL ORDER CHARGES	MAIL ORDER PERCENT
91	796,211	26,540	1,756,383	756,005	6,942	88,536	11.1%
312	690,817	34,961	3,208,286	1,159,984	5,485	79,602	11.5%
311	541,409	27,917	2,212,280	1,082,882	4,993	60,712	11.2%
412	540,496	50,270	2,959,696	2,245,902	10,521	52,714	9.8%
314	508,249	26,584	2,184,313	1,037,921	5,070	70,188	13.8%
234	385,153	11,052	891,494	316,088	3,076	33,392	8.7%
641	343,952	21,663	1,381,421	553,737	5,218	14,395	4.2%
317	275,322	8,882	1,002,323	281,042	1,647	36,651	13.3%
151	259,012	17,371	562,558	178,517	8,336	1,839	0.7%
281	222,841	16,036	1,357,713	442,004	2,242	24,044	10.8%
392	221,720	9,813	717,076	406,190	1,853	24,034	10.8%
313	211,919	6,934	777,146	231,822	1,276	32,578	15.4%
601	189,437	16,350	2,068,947	581,503	3,465	23,223	12.3%
522	175,947	14,327	659,764	258,445	4,964	8,403	4.8%
21	155,830	9,735	621,460	168,099	2,905	7,375	4.7%
614	154,425	9,071	161,671	192,024	1,418	9,024	5.8%
391	134,382	6,297	114,009	167,910	963	10,492	7.8%
22	91,038	10,000	478,912	113,182	3,293	1,129	1.2%
93	84,430	6,475	420,929	294,034	1,446	11,160	13.2%
643	81,208	5,266	332,173	167,794	1,251	4,054	5.0%
672	78,148	7,938	276,624	244,456	2,115	2,762	3.5%
521	66,901	4,480	278,111	183,615	1,477	6,962	10.4%
591	65,879	3,984	205,828	86,300	1,583	2,301	3.5%
642	64,528	3,456	223,872	108,298	800	3,857	6.0%
201	63,702	1,678	196,716	53,992	268	9,016	14.2%
315	61,047	13,717	878,968	752,798	3,566	5,204	8.5%
341	51,701	4,883	250,063	85,949	2,228	2,757	5.3%
302	50,471	1,024	65,205	27,928	276	3,964	7.9%
155	50,307	3,632	140,453	62,304	1,945	1,269	2.5%
170	48,675	4,054	229,189	74,686	1,667	1,434	2.9%
523	44,677	4,079	73,233	49,905	2,245	397	0.9%
721	41,648	6,113	471,864	357,511	1,618	4,262	10.2%
321	40,325	1,454	153,302	51,579	315	5,728	14.2%
154	38,689	2,528	134,197	50,790	1,064	3,372	8.7%
120	38,112	3,245	352,159	109,755	610	4,043	10.6%
820	36,800	2,109	138,718	83,530	481	3,395	9.2%
233	36,239	1,770	120,204	42,870	592	2,651	7.3%
374	34,003	2,261	98,852	36,321	1,073	2,182	6.4%
131	27,697	2,129	126,992	27,492	982	529	1.9%
111	25,664	2,436	147,460	103,787	624	3,122	12.2%
236	24,254	1,205	102,715	28,200	445	477	2.0%
344	23,770	2,891	453,496	26,108	1,591	104	0.4%
343	23,047	2,981	454,965	31,330	1,661	244	1.1%
141	21,398	2,534	132,766	59,103	1,136	1,371	6.4%
231	19,036	1,513	122,765	32,813	519	604	3.2%
202	18,534	1,355	100,476	43,142	301	1,275	6.9%
152	15,923	2,076	66,110	19,265	1,394	36	0.2%
232	15,399	1,911	186,536	46,595	713	1,312	8.5%
481	15,294	1,062	57,932	38,501	329	1,114	7.3%
788	12,795	472	121,182	8,044	164	189	1.5%

EXHIBIT 9: MDO OVER 65 CLAIM DATA

USC CODE	CHARGES	CLAIMS	UNITS	DAYS OF FILL	PATIENT COUNT	MAIL ORDER CHARGES	MAIL ORDER PERCENT
630	11,419	439	40,217	11,553	110	386	3.4%
235	11,259	690	46,127	17,017	236	1,164	10.3%
616	11,119	1,388	11,030	14,641	871	104	0.9%
671	10,240	1,751	161,203	57,548	471	340	3.3%
784	10,146	572	75,563	17,067	146	1,660	16.4%
153	9,889	721	68,478	17,826	288	603	6.1%
492	9,834	829	19,166	8,799	416	236	2.4%
182	8,033	600	21,361	18,230	208	60	0.7%
762	7,607	773	40,609	31,396	198	470	6.2%
690	7,336	427	41,724	7,104	254	176	2.4%
761	5,793	677	38,348	28,680	193	410	7.1%
740	5,397	149	10,166	5,945	29	1,258	23.3%
373	5,181	376	21,183	6,844	192	425	8.2%
372	5,165	540	21,325	5,612	296	125	2.4%
723	4,919	492	66,118	8,701	251	413	8.4%
528	4,865	115	6,487	3,846	23	888	18.3%
563	4,816	243	124,546	3,191	62	105	2.2%
160	4,647	176	12,443	7,219	53	1,176	25.3%
613	4,161	513	7,959	7,653	305	20	0.5%
12	3,669	185	13,408	2,573	142	114	3.1%
393	3,154	98	6,285	3,541	24	202	6.4%
301	3,154	180	8,466	4,298	49	51	1.6%
282	3,048	158	9,440	3,125	63	419	13.7%
435	2,946	154	3,260	1,400	57	0	0.0%
483	2,519	303	7,541	8,720	131	0	0.0%
431	2,509	166	17,239	1,545	61	0	0.0%
783	2,286	86	5,935	2,531	18	33	1.4%
763	1,873	235	9,827	10,047	86	121	6.5%
376	1,704	208	27,286	3,915	122	47	2.8%
526	1,649	105	7,943	3,954	21	46	2.8%
644	1,561	192	19,186	6,290	41	22	1.4%
484	1,438	304	23,429	13,289	98	69	4.8%
602	1,348	170	36,523	5,883	78	122	9.1%
781	820	68	51,255	2,764	29	200	24.4%
607	720	59	9,732	1,111	13	0	0.0%
611	719	13	2,100	556	4	471	65.5%
617	380	47	2,772	1,295	19	66	17.4%
450	243	13	1,780	469	9	115	47.3%
51	102	11	7,880	406	6	0	0.0%
998	7,396,129	444,740	31,334,847	13,918,636	115,819	681,595	9.2%
999	7,418,574	446,670			116,819	681,683	9.2%
900	99.70%	99.57%	N.A.	N.A.	99.14%		

998 Sample Totals
999 Total All USC Classes
900 Ratio of Sample (998) to Total (999)

American Association of Retired Persons
Report
on
Prescription Drug Survey

Prepared by
Barbara K. Pequet

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EXECUTIVE SUMMARY

In the fall of 1982 the American Association of Retired Persons conducted a national survey of Americans over 45 years old to explore thoroughly these older consumers' practices and information levels when using prescription drugs. AARP was especially interested in the opinions and practices of older people, age 65 and above, and whether these were different than younger Americans, 45 to 64 years old.

There are six important findings from the survey.

First, older people use more prescription drugs than do other consumers. They are 2 1/2 times more likely to have three or more current prescriptions than are younger people in this survey (24% v. 9%). Approximately one out of three elderly people use no prescriptions whatsoever.

Second, consumers choose not to comply with a prescribed drug program relatively frequently. Non-compliance most often takes place when consumers stop taking a prescription drug mid-process. Even though the medicine has not been depleted, two-fifths of those surveyed say they have stopped taking it at some stage prior to completion. Another one-fifth say they have refused, at least once, to have a prescription filled. This action was attributed to concern for side effects, an improvement in their health condition, or a belief that the prescription was or would be unhelpful. A majority of people who did not follow their doctor's orders at this stage were not likely to tell their doctors of such action.

Third, a plurality of the surveyed public (40%) have experienced a side effect from prescription drugs. Half of these (49%) say doctors do not always tell them about possible side affects and a majority (53%) claim pharmacists never convey such information. Older people receive less side effect information from physicians and pharmacists than does the general public.

Fourth, respondents hold high expectations that doctors and pharmacists will provide all the information on prescription drugs they will need. Consumers are often passive in asking questions; 44% ask no questions at all when their doctor prescribes a new drug for them. On the other hand, neither doctors nor pharmacists provide consumers with much crucial information. Older Americans are less likely to receive information from these two professionals than are younger consumers.

Fifth, even though those surveyed do not receive the information they desire and need from physicians and pharmacists, those information sources are the public's favorites. The next most preferred source of information on prescription drugs is a printed leaflet to be given out to patients by doctors or pharmacists. Respondents not only want printed information leaflets, but a very strong majority is willing to pay a reasonable price for them.

Finally, most consumers surveyed know about but do not frequently try to buy generic drugs. A noteworthy portion of the public are confused or uninformed about the safety and quality standards for drugs. This confusion may account in part for why only 42% of the generic-knowledgeable public try to obtain less-expensive generics whenever possible.

These observations are background to the major findings and implications examined in the survey report.

INTRODUCTION

Since its founding in 1958 the American Association of Retired Persons has represented the interest of its members, over 16 million older Americans. Through research, education, advocacy, community projects, and service programs, AARP has helped older people achieve and maintain independent, purposeful lives.

Staying healthy is a top priority for older Americans, and because the elderly use more prescription medication than any other age group, good health for older Americans depends more than ever on using medicine properly and wisely.

But the availability and communication of consumer drug information does not appear to have kept pace with the public's desire for this information. This era of our history may well be referred to as the Dark Ages of prescription drug information. Certainly it is a paradoxical time -- when the government requires full disclosure of warnings, side effects and drug interactions on less dangerous non-prescription drugs and no disclosure whatsoever on nearly all of the more potent prescription drugs.

On the economic side, older Americans pay more to maintain good health than individuals in any other age group. The elderly comprise 11% of our population, but account for 25% of total prescriptions. Some 84% of their drug expenditures are paid out-of-pocket. Unlike many other advanced countries, the U.S.

does not cover outpatient prescription drug costs in its medical care program for the elderly nor does it limit drug prices.

HIGHLIGHTS

1. Older Americans use more prescription drugs than others do. Consumers over 45 years old are as likely as not to be taking a prescription drug. But older Americans (65 and older) are 2 1/2 times more likely (24% vs. 9%) to be taking three or more prescription drugs on a regular basis than middle-age persons (45 to 54). A large majority of Americans (84 %) over 45 take two or less prescription drugs at a time.

2. A significant number of consumers do not follow through on prescription drug programs. Two out of five consumers have quit taking a prescription before all the medicine was used, and one out of five has not filled a prescription at one time or another. Consumers cite their concern for side-effects, the belief that the drug would be, or was being, unhelpful, and an improvement in their condition, as the chief reasons for their non-complying actions.

3. Side effects are experienced by two-fifths of the surveyed public, a large majority of whom are not forewarned. Consumers report that large percentages of doctors and pharmacists never give them information on side effects. Older Americans feel they receive the least information of all people over 45 years old.

4. The public looks to doctors as their primary source of information on general health issues and prescription drugs. They expect doctors to tell or give them all the information

needed since a large number of consumers ask no or only a few questions. Very few consumers ask about non-drug alternatives.

5. Consumers say doctors do not provide adequate information on prescription drugs. Many consumers say their doctors do not always give them thorough information about side effects, serious adverse reactions, alternative therapies, and other basic information. Older Americans receive less information from their doctors than do other consumers.

6. Consumers say pharmacists do not provide adequate information on prescription drugs. A majority of the respondents is not informed consistently about such things as side effects, adverse reactions, storage requirements, and numbers of refills. Older people more often report their pharmacists do not give them this basic information than do other people 45 years and older.

7. The surveyed public want printed leaflets of prescription drug information. Doctors and pharmacists are the public's favorite sources of patient prescription information, but printed leaflets which can be read and reread, are, for a strong majority of the public, the third preference as an information source.

8. Respondents are willing to pay the necessary costs of printed leaflets. Americans would not pay extravagant prices for drug information, but three-fourths of the public are willing to pay up to five cents per leaflet, the estimated cost-range to produce the leaflets.

9. Public knowledge about generics is fairly broad but often shallow. 60% of the public, and a smaller number, 53%, of the elderly population, know about generics. A sizable portion of these consumers, however, do not have the correct facts on safety and effectiveness.

10. Consumers' use of generics is modest. Only 42% of the surveyed public who know about generic drugs say they try to buy and use them, but three-fourths of them admit to not asking their doctors to prescribe or their pharmacists to dispense generics. Consumers who buy generic drugs are usually better educated than those who do not use generics.

THE SURVEY OVERVIEW -- FINDINGS AND IMPLICATIONS

PRESCRIPTION DRUG CONSUMERS AND THEIR PRACTICES

Summary

As society increasingly believes there is a pill for every ill, as drug consumption surpasses population growth, and as new chemical entities pour onto the market, Americans are exposed to more and more prescription drugs.

These high-potency medicines are used by more than half the American population older than 45. The heaviest concentration of usage is among elderly Americans, those people 65 years and older, who are more likely than any other age group in this survey to be using between three and ten prescription drugs.

The surveyed public apparently feels ambivalent about the good prescription drugs do for them. A significant portion of the respondents often do not comply -- either do not begin or do not complete -- the drug-taking process. One-fifth of all respondents at one time or another have not filled a prescription ordered by their doctor. Two-fifths have on occasion stopped taking a prescription before the medicine was used up.
Two principal explanations account for this non-complying behavior: fear of side effects; and belief that the drug was not or would not be helpful. A third explanation is that the condition improved. These reasons for non-compliance are based on known dangers and experiences as well as suspected dangers

and inadequate information about side effects and drug effectiveness. Thus, some consumer non-compliance is partly attributable to the need for more, precise, and thorough information.

Despite the surveyed public's loyalty to one doctor and pharmacy, many consumers do not tell their doctor when they decide not to follow a drug program. This independence of action outside the doctor's office is another facet of the survey's indications of poor patient-doctor communication.

Side effects were reported by 40% of all prescription drug users surveyed. Many of those reporting side effects said they had no forewarning that a side effect might occur. Consumers reported they are not consistently receiving basic information on the functions and effects of prescription drugs from doctors or pharmacists, a necessity if consumers are expected to comply with drug programs and if the public's health is to be protected.

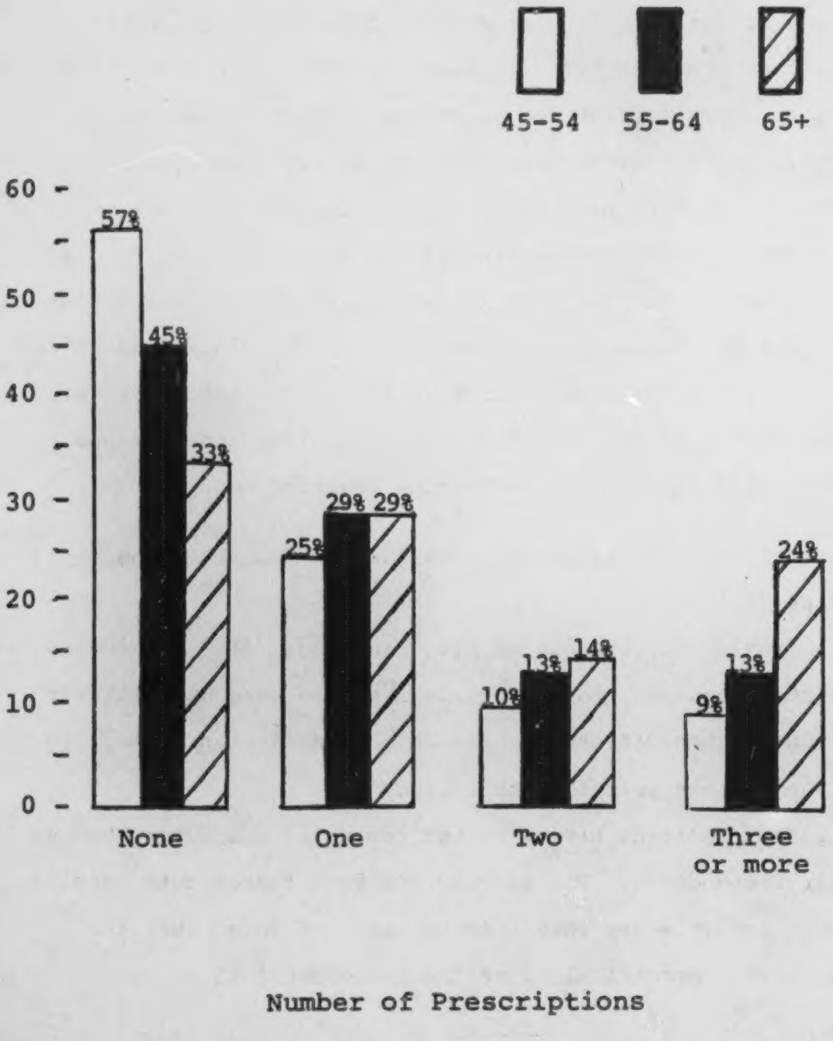
Prescription Drug Patterns -- Who Takes How Many Drugs Regularly?

Prescription drugs are products which cannot be sold over the counter in the open market. Their potency and toxicity are severe enough to warrant professional monitoring of use and distribution. Thus, when approximately every-other-person (55%) in America 45 years old and over takes at least one prescription drug, a significant portion of the population is under medication. Prescription users, however, generally are not excessive in the numbers of different drugs they take. Of those who use prescription drugs, most (70%) use no more than two drugs and only one out of four (28%) people use three or more prescriptions regularly. Most Americans use a moderate amount of prescription drugs.

Unfortunately, as Table 1-1 shows, moderate usage is not evenly distributed across age groups. Older Americans, 65 and above, take the greatest number of prescription drugs. Although 33% of all older Americans take no prescription drugs whatsoever, two-thirds (67%) do, a higher percentage than any other age group. Within that group of elderly prescription users, 64% currently use one or two prescriptions. That means 36% of all prescription using respondents who are 65 years and above take three or more drugs. As compared to the 9% of drug consumers who are 45 to 54 years old, and use three or more prescription drugs, older Americans are two and one-half times more likely (24%) to use that quantity of drugs.

Table 1-1

Use of Prescription Drugs by Age



Other personal characteristics, such as race or education are not as significant as age in distinguishing patterns of prescription drug use. In general the frequency of this drug use among whites and non-whites, more-and less-educated is roughly equal.

How Well Do Consumers Comply with Prescription Drug Regimes?

Although a majority of consumers comply with their doctor's orders for both filling prescriptions and taking the drugs, a significant number do not. AARP first explored consumers' compliance behavior patterns in 1981. In that year three out of four (76%) older Americans claimed always to take the drug a doctor prescribed. The 1982 survey questioned respondents more specifically. Overall, non-compliance by Americans aged 55 and older was about the same in 1982 as it was in 1981. However, an examination of the stages of the medication process show where the fluctuations in compliance behavior occur.

On Not Filling the Initial Prescription -- What Are Consumers' Practices?

Approximately one out of five Americans (21%) has chosen, at one time or another, not to follow from the very outset their doctor's recommendations for taking a prescription. They did not have the written prescription filled.

Older Americans have a better record at complying than do younger respondents. The elderly are more disposed to resolve whatever ambivalences they hold in favor of doing what the doctor says. Specifically, of the respondents 65 years and older only 14% have chosen at some point not to fill a prescription, leaving 86% who always fill prescriptions. By contrast almost twice that number of the middle age respondents, 26%, did not fill prescriptions, with little difference on the basis of sex, race, or income.

Of the overall 21% of consumers who did not fill prescriptions, a number of reasons were offered to account for their non-complying behavior. The largest number, 31%, of respondents thought the drug would not help much. Whether these patients had previously taken the same drug, did not have enough information to evaluate helpfulness, or had some other reason for skepticism is not known. The elderly cite this lack of belief in the drug's effectiveness as a reason not to comply as frequently as do other non-complying consumers.

The second reason cited by this group, who decided not to fill prescriptions, is concern over the side effects of the drug. While 42% of older respondents who have not filled prescriptions said they were afraid of experiencing side effects, only 30% of the noncompliers in general cited this reason.

Of all the non-filling respondents, one out of five (20%) did not fill prescriptions because their condition improved sometime between visiting the doctor and the pharmacy. Although this may seem to be an obvious and rational reason for not following the doctor's orders, in fact, it may be harmful.

Symptoms can disappear even though the underlying health problem prevails. In such cases, use of the prescription may have helped cure the illness.

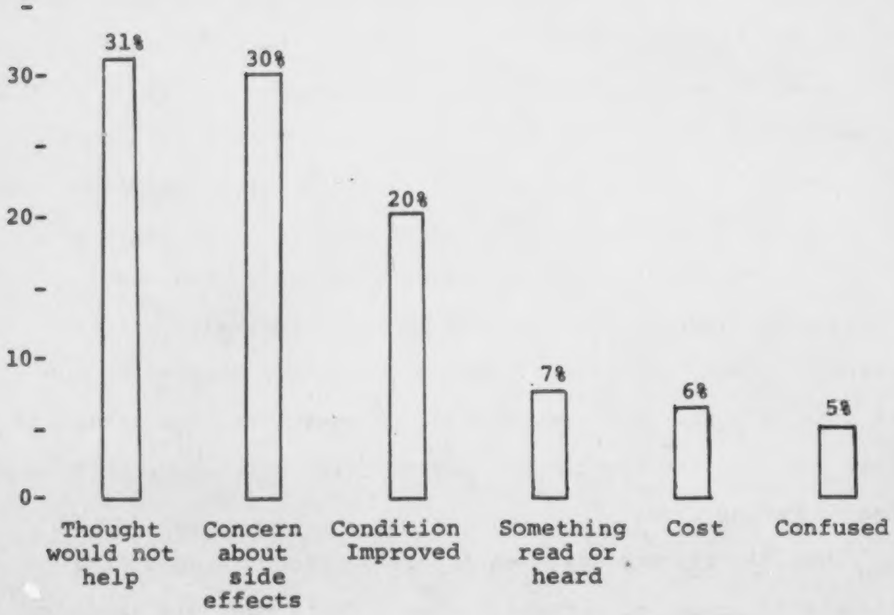
A handful of other reasons, such as something read or heard about the drug, cost of the prescription, confusion about the drug, or fear of addiction, were cited as additional explanations for not having prescriptions filled. However, none of these ranks as a primary motivation for not complying for most consumers. Several reasons imply consumers need more information. In future surveys it would be interesting to learn whether more facts and information about a drug would reduce skepticism and the resulting non-compliances.

Importantly, very few non-complying consumers, only 6%, said the cost of medicine prohibited them from filling prescriptions. Whether sacrifices in the other basic necessities, such as food or transportation, had to be made to pay for drugs is unknown.

Table 1-2 shows the reasons given by consumers for not filling prescriptions their doctors have given them.

Table 1-2

Reasons for Deciding Not to Fill Prescriptions



On Discontinuing Already Filled Prescriptions -- What Are Practices?

This year a specific question asked respondents when non-compliance occurs and why. Almost twice as many consumers have not complied with a drug regime after they have filled a prescription as the number of those who never began. Approximately 39% of the people who have obtained prescription drugs later decided to stop taking the medicine.

Here, as in the non-compliance prior to filling the prescription stage, older Americans are not as likely as others to be among the non-compliers. About one out of three (33%) Americans 65 and over have filled and then decided to stop taking a drug, while 43% of the middle age respondents have done so.

In the follow-up question respondents who discontinued using a prescription drug they had already paid for were asked to give their reasons. Three primary reasons emerged. The most frequently cited explanation was concern about side effects. A surprising 49%, every-other-person, said they stopped because of side effects. The respondents, however, were not asked if they actually had experienced adverse side effects or only feared having them.

The elderly more frequently discontinued using a drug because of actual or potential side effects than did other age groups. Older Americans are more disturbed (55%) about side effects and concerned enough to discontinue a drug than are middle age people (42%). This concern for side effects is even stronger (60%) among non-complying respondents 75 years and older. This might be explained in part by the fact that older Americans more often take multiple prescription drugs than do their younger counterparts, have lower tolerance levels than do younger people, and have had both greater opportunity and time to experience or anticipate side effects.

A second reason, cited by 25% of the people who discontinued a drug, was an improvement of their condition. Unfortunately, like people who do not fill a prescription when symptoms abate, people who discontinue a drug may not be fully restored to health.

The third reason given by non-complying consumers who discontinued a purchased drug is the evaluation by 21% of them that the drug was not helping much. Respondents were not asked to elaborate.

What About Lack of Information About a Drug as Grounds of Non-Compliance?

The above three classes of explanations were given by a very large majority of all respondents as the most common reasons to contradict the doctor's orders. Responses to another AARP survey question, however, reveal yet another reason may exist -- lack of information. Respondents were asked to describe their various reactions when they still had questions about a drug after leaving their doctor's office. For example, one possible reaction would be to call the doctor's office and talk to the doctor or nurse. 81% of the respondents said they always or sometimes talk to their doctor. 56% reported they always or sometimes talk to a nurse or other health professional in the doctor's office. 74% reported they always or sometimes ask their pharmacist. But almost one in three, 29%, reported they always or sometimes do not take the drug.

Do Consumers Practice Self-Medication?

Consumers do intervene and act independently in the drug programs established by their doctors and usually for identifiable reasons. Reasons such as fear of side effects, lack of confidence in the drug, an improved condition, or lack of information seem to explain this behavior.

Although consumers may ignore orders when they are not convinced of the effectiveness of a drug, this independence stops far short of self-medicating. Consumers are not so independent of doctors and pharmacists that they initiate risky or dangerous measures. Contrary to the myth, consumers infrequently borrow (7%) or loan (10%) medicine. Of those few who do swap medicines, the larger group of respondents who either borrowed or gave drugs are more likely to be middle-age consumers (17%) than older Americans (9%).

Similarly, the allegation of the drug-demanding consumer may be exaggerated. Less than one-fifth (18%) of the respondents said they have ever asked their doctor to prescribe a specific drug. Of the few who have, however, many (74%) asked for the drug by name. And of the small number who asked for a specific drug, many (78%) received the drug. It appears from these figures that doctors either like to fill the requests of their patients or that the few consumers who request specific drugs are highly accurate in their self-diagnosis.

Finally, some non-compliance results from sheer mistake. When those mistakes happen and a drug therapy is not followed unintentionally, consumers seem to take reasonable steps to resume compliance. For example, over two-thirds (70%) of all respondents who missed taking a dose of a prescribed drug did nothing extraordinary. They simply waited until the next dose was due and then resumed their schedules. Approximately one-twelfth (8%) adjusted their schedules for the rest of the day. Only 3% mistakenly took a double dose when the next dose was due.

What Does Non-Compliance Say About the Doctor-Patient Relationship?

In general consumers are loyal to one doctor, one dentist, and one pharmacy. Even though the number of prescriptions per consumer increases with age, the number of prescribing doctors stays low. 94% of all consumers receive all their prescriptions from no more than two health professionals, including their dentist, while 77% of the respondents patronize only one pharmacy.

When, in spite of loyalty, consumers do not comply with a drug therapy, and when they do not tell their doctors, the patient-doctor relationship is not working. Of the 21% who did not fill a prescription, more than half (52%) did not inform their physicians of their actions. Numerically, 108 of the 1001 respondents did not begin a drug treatment their doctors thought they were taking and did not let their doctors know. For these people it would seem the bases for the patient-doctor relationship are not information sharing and trust.

Consumers who do not use all their medicine, or alter in some manner the program ordered for them, are better about letting doctors know of their changes. Only one-third (34%) of these respondents did not tell their doctor of their independent actions. It should be repeated, however, that among those 65 and older non-compliance was less frequent and telling the doctor about alterations was more likely to occur.

It is possible that consumers regard non-compliance by discontinuance the lesser of the two wrongs, since more consumers quit complying at this stage and more tell their doctors about their actions. But to what degree does the quality of the doctor-patient relationship influence both compliance and open information sharing? And do doctors give enough information about drugs to prevent the uncertainty which may lead to non-compliance? It might be worthwhile in future surveys to explore more closely the relationship between compliance, information and the patient-doctor relationship.

Concern About Side Effects Is One of the Major Reasons for Non-Compliance. How Often Do Side Effects Occur? Who Experiences Them?

The 40% of respondents reporting side effects were asked to rate the severity of the side effect on a scale ranging from 1 or mild to 5 or very severe. More than a quarter (29%) of this group reported "very serious" side effects. The older side effect sufferers reported a similar proportion (30%) of "very serious" side effects.

While the total number of people who reported "very serious" side effects is relatively small, the age patterns suggest a possible cause for concern. Only 3% of side effect sufferers of all ages reported hospitalization as a consequence, but 6% of side effect sufferers age 65 and older reported going to the hospital as a consequence. It must be noted, however, that this represents only 2% of all the older people in the survey.

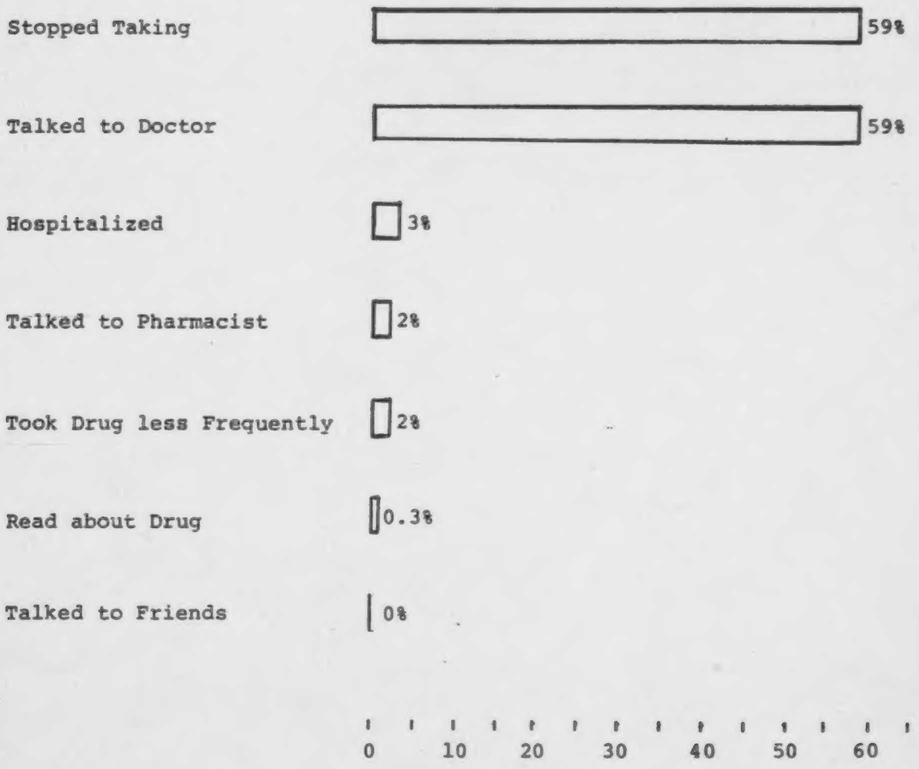
What Do Consumers Do When a Side Effect Occurs?

Another question asked side-effect sufferers what actions they took after experiencing their last adverse reaction. A majority of these people took more than one action. 59% stopped taking the drug altogether, and 59% also returned to or called their doctor for more information. Interestingly, while older side effect sufferers were just as likely as other age groups to stop taking a drug due to adverse reactions, they were less likely (47%) to contact their doctor. These are the only two steps taken by a majority of the suffering respondents. A few others talked to the pharmacist (2%) or took the drug less frequently (2%). Table 1-3 shows the various actions respondents took and the percentage of respondents who choose each option.

Table 1-3

Action Taken After Experiencing Last Side Effects

(Base = 398 Side Effect Sufferers)



Are People Being Forewarned About Side Effects?

Many consumers report they are not receiving the information they need. A majority of the respondents (52%) said that their doctors do not always provide them with information about possible side effects. In response to a parallel question, an even larger majority (59%) reported not always being given information by their physician as to what to do if a bad reaction occurs. Table 1-4 shows the breakdown in percentages of the quantity of side effect information consumers of different ages receive from their primary care doctors.

Table 1-4

Frequency of Side Effect Information
Dispensed by Doctors and Pharmacists

		Always	Sometimes	Never
Normal Side Effects	Doctors	46%	20%	32%
	Pharmacists	23%	21%	55%
What to do if bad reaction occurs	Doctors	39%	18%	41%
	Pharmacists	20%	15%	63%

Pharmacists could be expected to be another crucial source of side effect warnings and information. Instead, 55% of all respondents and 62% of the older people said they never receive information about normal side effects from their pharmacist. Pharmacists, like doctors, are even less likely to tell consumers what to do if a bad reaction occurs. 63% of all respondents and 68% of the older people said they never receive that information from pharmacists. See Table 1-4 for a comparison of doctors and pharmacists in dispensing information on side effects.

SOURCES OF INFORMATION FOR PRESCRIPTION DRUGS

Summary

Americans today have many sources of information on health and drugs. Nonetheless, the primary care or family doctor remains the number-one source of all types of information for consumers.

The public often expects doctors and pharmacists to provide them with the information needed about prescription drugs. While 44% of those surveyed report they "never ask any questions" of their doctor, those who do are most likely to ask about side effects. Consumers rarely seek non-drug, alternative remedies to prescription drug therapies.

Many doctors provide consumers with some basic drug information. However, consumers reported that doctors do not consistently inform drug users about side effects, serious adverse reactions, or alternative therapies. At the same time, 45% said doctors do not find out about other prescription medicines their patients are taking. Elderly consumers, more than others, feel their physicians are not thorough in providing necessary information to them.

Pharmacists are considered a principal source of prescription information by 25% of consumers. But a majority of the respondents reported that pharmacists do not routinely provide information about such basic things as side effects and adverse drug reactions. Older Americans feel they receive even less information than do other age groups. While 9% of consumers are of the opinion that pharmacists should keep records of their patients' use of over-the-counter and prescription drugs, a majority of consumers, 48%, believe it is their own responsibility to keep track of the medical drugs they use.

The American public is not receiving the thorough, basic information they need the way they would like. While the first two sources consumers reported they typically turn to for information about prescription drugs are the doctor and the pharmacist, respondents reported low levels of information actually received from them. The third most preferred source of information is a printed leaflet or pamphlet provided by the doctor or pharmacist. Yet, here too, there is a gap between preference and practice: while approximately 60% of those interviewed said they would like to read such a pamphlet or leaflet, a majority of respondents reported that their doctors and pharmacists never provide such printed information.

What Are the Various Sources of Health and Wellness Information?

A majority of consumers (52%) feel their principal source of information about health in general is not any one segment of the media, not school, not family and friends, but their primary care doctor.

Doctors stand above all others as sources of information, and especially above others in the health profession. For instance, less than one out of ten consumers (9%) regard pharmacists, or other health professionals (5%) as primary sources of general health information. After the doctor, consumers rely on printed texts -- books, newspapers, and magazines -- to provide information on general health issues. Table 2-1 compares the principal sources of information on general health and prescription drugs.

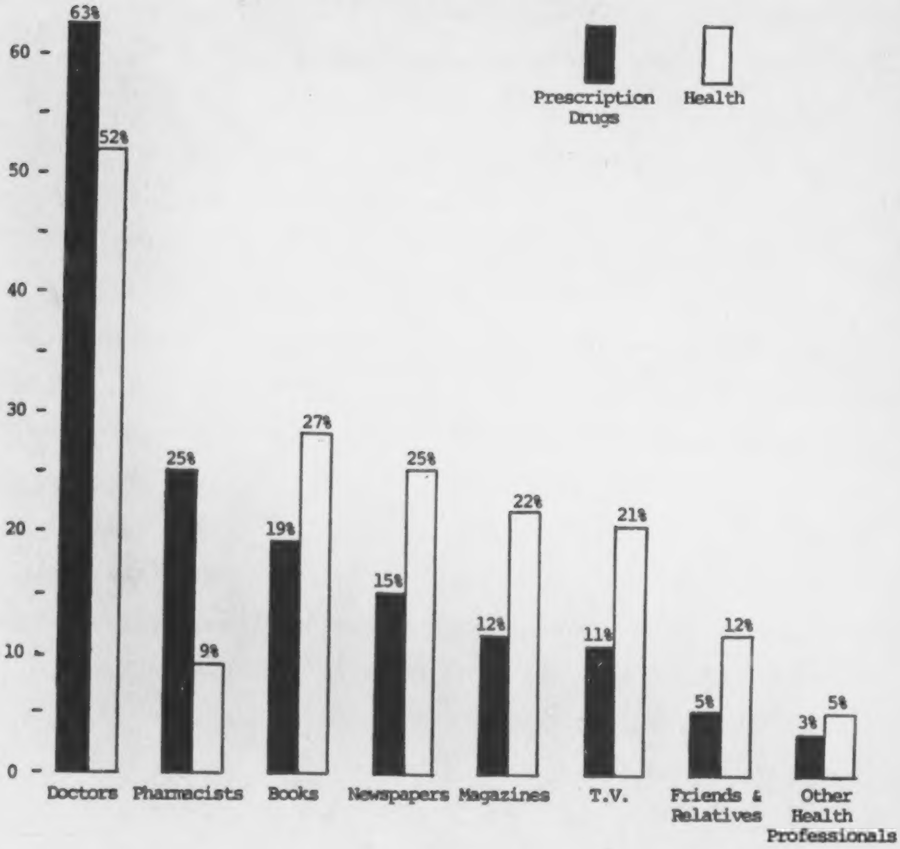
What Are the Principal Sources of Prescription Drug Information?

Doctors are regarded by many consumers (52%) as important for general health information, but an even larger majority (63%) turn to their doctor for information about prescription drugs. Pharmacists are also a principal information source about prescription drugs, but to far fewer consumers -- only 25% of the respondents. Ranking third are printed materials such as books, newspapers and magazines. Table 2-1 lists the different sources of information and their importance to consumers.

Table 2-1

Sources of Information on General

Health and Prescription Drugs



Past research has shown that people are often not prepared to make informed health decisions in the field of prescription medicine. The AARP survey introduced a series of questions on the roles of physicians, pharmacists and consumers in the information process to learn where problems exist.

1. Consumers as Information Gatherers.

Although consumers are probably more informed and assertive than they have been in the past, the consumer role in gathering health information from the physician is often a passive one. Presented with a new prescription, consumers frequently do not ask for basic, necessary drug information from their primary care doctor.

Surprisingly, almost half (44%) of all respondents admit they ask no questions whatsoever of their doctor. They are open to receiving information given to them, but these people do not initiate questions. This passiveness is shared fairly equally by respondents at all age, income and education levels. Men are as unquestioning as women. No specific characteristic established by this survey seems to distinguish the respondents who never ask questions from those who do.

What Questions Do Consumers Ask Doctors?

The question most commonly asked by respondents is what the possible normal side effects of a drug may be. However, only one-fourth (27%) of all respondents ask for this information. Among those, older people are less likely (21%) than the middle aged people (31%) to make inquiries about side effects.

Of all the respondents who had previously experienced side effects, over a third (37%) say they now inquire about such results. Here experience teaches, it seems, but does not cause large scale improvements in consumer seeking of information on side effects.

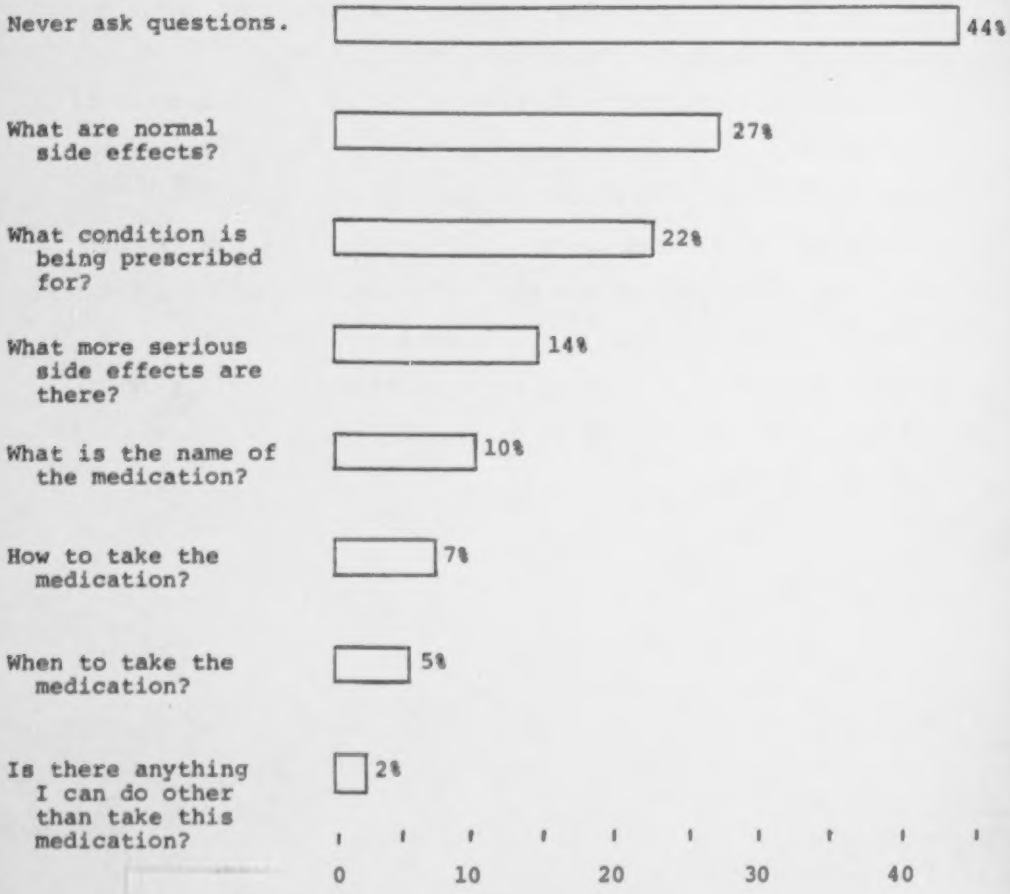
The related questions about what more serious side effects might be possible is asked by only 14% of all people. So few consumers make this inquiry, that observations about their shared characteristics are not supportable numerically.

The second question most frequently posed by consumers to their doctors is "What condition is the drug being prescribed for?" Twenty-two percent of all respondents ask it.

Beyond these three questions, only small numbers of the respondents consistently ask for other information. For example, only one out of ten (10%) inquire about the name of their medication. The list of questions respondents say they ask doctors and the percentage of people who ask these questions is shown in Table 2-2.

Table 2-2

Questions Asked of Doctors by Consumers



The questions not asked, or asked by only a small number of respondents, indicate how superficial consumer knowledge about medicinal health care may be. For instance, the following basic pieces of information are inquired about by significantly less than 10% of the respondents: how to take a drug; when to take a drug; how many times to refill the prescription; whether or not drug is addictive.

Do Consumers Ask About Alternatives to Prescription Medicine?

No. Americans have held a strong general consensus for the last decade or two that we are an over-medicated society. Respondents in the 1982 survey share that sentiment. Seventy-nine percent of them believe most Americans take too many drugs. In spite of that conviction, only 16 people out of 1001 respondents (1.6%) ask their doctor if there is another, non-drug method for treating their specific health problem.

How Do Consumers Assess Their Role?

In spite of the number of questions which go unasked by many people, most consumers do not think of themselves as passive. A majority of the respondents (54%) say they always or sometimes ask their doctor about these routine but vital pieces of information. A sizeable number are not active participants in gathering information about their prescription drug therapies: 44% say they never ask any questions. A slightly higher portion of the older respondents (49%) state that they never ask any questions.

2. Doctors as Information Dispensers.

Physicians, as evaluated by the participants in this survey, are not adequately informing patients about some important aspects of the drugs they prescribe. To be sure, they do a very good job in a few information areas. Better than three out of four respondents said their doctors always do tell them how (85%), when (84%), and why (77%) to take a drug--the condition it is being prescribed for--but other very important information is not conveyed to patients consistently.

What Information Are Doctors Not Giving Consumers?

Consumers need more information about adverse reactions. Close to one-third (32%) of all respondents reported that their doctors never tell them what the range of side effects for the prescribed drug may be. In that same area, well over a majority of the respondents (59%) said they are not told consistently what they should do if a bad reaction occurs. (41% are never told; 18% are sometimes given this information.)

Consumers are not receiving information about other options to a prescription drug therapy. Two out of three respondents reported that their doctors never discuss what might be done to restore or ensure good health instead of taking a prescription drug. In the subgroup of respondents who do talk with their doctors about other methods of cure, only 26%, one-fourth of these people, choose not to take the recommended drug.

Table 2-3 indicates the type and frequency of information consumers reported their physicians give to them.

Table 2-3

Information Consumers Reported Doctors Give

(All Consumers Compared to Those Over 65)

Type of Information	(Age)	Always	Sometimes	Never
Name of drug	All	61%	18%	20%
	65+	59%	16%	23%
Condition for which drug is being prescribed	All	77%	14%	7%
	65+	75%	15%	9%
How to take it	All	85%	8%	6%
	65+	82%	8%	8%
What you might do instead of taking drug	All	16%	14%	68%
	65+	10%	13%	73%

Is There Information Doctors Are Not Receiving from Consumers?

In order to know what information patients need, doctors must ask for information *from* their patients. Yet, a sizeable plurality of respondents (47%) claimed their doctors never ask what non-prescription drugs they are taking. More seriously, almost 45% of the respondents stated their doctors do not always check to find out what other prescription drugs the respondents may be taking.

What About the Elderly and Information from Doctors?

The older consumers, 65 years and above, may be, of all the consumers surveyed, the least informed by doctors. When asked about the different types of information listed in Table 2-3 conveyed by doctors to consumers, a greater number of respondents 65 and over reported their doctor never told them the designated information. Similarly, older Americans claimed never to be asked about other over-the-counter and prescription drugs at a greater frequency than the other respondents.

3. Pharmacists as Information Sources.

The pharmacist is the next favorite information source after the doctor. Forty-one percent of all respondents said they always turn to the druggist for answers to the questions which arise after leaving the doctor's office. Another 33% sometimes contact the pharmacist for additional information.

What Information Are Pharmacists Giving Consumers?

A majority of the respondents reported that their pharmacist always tells them some of the most basic information -- how to take a drug (52%) and when to take it (50%). Table 2-4 lists the items of information consumers reported pharmacists convey and the frequency with which that information is given.

What Information Are Pharmacists Not Giving Consumers?

According to the respondents, pharmacists are very inconsistent in providing vital information. Some pharmacists routinely and dependably give out certain kinds of information. Others never verbally or in writing present their clients with particular types of information. For example, the name of a drug is basic information a pharmacist would give. Thirty-six percent of the respondents claimed their pharmacists always give the name of a drug, while 43% say they never do. Similarly, 44% said they always are told the number of refills to get; 37% claim they never are told.

The largest majorities do not consistently receive information from pharmacists about side effects and adverse health reactions. Fifty-five percent stated they never are told the normal, predictable side effects of a drug. Even more, two-thirds (63%) never are warned of what to do if a bad reaction takes place.

Other necessary information also is disseminated randomly to many consumers. For instance, every other purchaser (51%) is never told by the druggist how to properly store the drug. About half the public (50%) never learns from the pharmacists what condition the drug product they are purchasing is prescribed to treat. Table 2-4 illustrates the wide inconsistency in information distributed to consumers.

Table 2-4

Information Consumers Reported Pharmacists Convey to Them

(All Consumers Compared to Those 65 and Over)

Type of Information	(Age)	Always	Sometimes	Never
Name of drug	All	36%	21%	43%
	65+	37%	16%	46%
Condition for which drug is prescribed	All	27%	21%	50%
	65+	29%	16%	53%
How to take it	All	52%	16%	31%
	65+	47%	15%	37%
How to store	All	28%	20%	51%
	65+	24%	21%	55%
Drug's side effects	All	23%	21%	55%
	65+	21%	15%	62%

What Accounts for This Information Failure?

Consumers' communication with their pharmacists is consistently lower than with their doctors, according to the survey. While patients do not seek out drug information from pharmacists as frequently as they do from doctors, neither are they receiving as much information from pharmacists as they do from physicians.

Even though 17% of the respondents know that a book about drugs is available for public use at their pharmacy, a majority (55%) have no idea if such a resource exists at the drug store they patronize most frequently. Further, of those who are aware that such an information source is available, slightly less than one third (30%) have ever used it, and they amount to only 5% of the entire number of respondents of the survey.

Similarly very few consumers have ever directly asked their pharmacists for any printed information. Although most people (91%) who asked for printed information received it, this subgroup comprises only 16% of the total respondents. Printed information from pharmacists is not reaching enough consumers to fill the need for basic facts about prescription drugs.

What About Older Americans and Information from Pharmacists?

Elderly respondents (40%) are as willing as the others to turn to their pharmacist to seek additional prescription drug information. In contrast, however, more people who are 65 and older than younger and middle age respondents feel they never are told needed information in the categories listed in Table 2-4. It appears that older Americans are the least informed by pharmacists about the standard use, purpose, possible dangers, storage, and effects of their prescription drugs.

Do These Information Gaps Create A Break in Confidence Toward Pharmacists?

In spite of the fact that consumers are not receiving needed information from pharmacists, they nonetheless have a strong trust in pharmacists to keep track of all prescription as well as over-the-counter drugs they take. This rather contradictory belief is shared by a large majority of respondents. Two-thirds (67%) think their pharmacist knows all the prescription and non-prescription drugs they ingest. This confidence in a vigilant pharmacist is most common among the elderly population (72%) and people earning less than $10,000 (76%).

On the other hand, the public (91%) also believes that the pharmacist is not the most important person to keep track of all the drugs they take. Over one-third (38%) believe their doctors should have the main responsibility of keeping track of all drugs they use. Older people are slightly more likely (42%) to expect the doctor to keep track of their medicine patterns than are middle age respondents (36%).

Although 59% do not keep a list of all the drugs they take, a strong plurality (48%) think they, the consumers, should be the ones to keep track. Interestingly, women are more inclined than men to believe they should be the responsible agents, by a 5:4 ratio.

4. Other Sources of Prescription Information. What Sources do Consumers Want to Use?

This survey has confirmed again the fact that when consumers need information they traditionally go first to their doctor, and second to their pharmacist. But there are other sources. When asked what actions consumers take when they find they need more information, 27% of the respondents said they read about the drug.

In another question designed to explore specific consumer preferences for sources of information, respondents were asked to indicate which of eleven options they would be likely to use. After consulting with the doctor and pharmacist, a large majority of people said they would be likely to do two very similar things. First, 62% would read a leaflet the doctor gives with a prescription. Second, 58% would read a leaflet the pharmacist gives with the medication. Even though printed leaflets from doctors and pharmacists rank a high third as a preferred information source, currently they are not widely available or disseminated. Additionally, consumers almost never ask their doctor for leaflets (only one half of one percent ask), and only a few respondents to the survey have ever requested informational leaflets from their pharmacists (18%).

Respondents reported other options they would use. For example, 47% percent would read a drug information column in a magazine. Slightly less than a majority of respondents thought they would read a periodic newsletter (41%). Others felt a call by way of a 800 toll-free line to a drug information center would be useful (33%). Table 2-5 lists the actions consumers would be likely to take to obtain more information about prescription drugs.

Table 2-5

Consumer Preferences for Obtaining Additional Information

	All Respondents	65 and Over
Ask Doctor	88%	90%
Ask Pharmacist	69%	66%
Read leaflet from Doctor	62%	60%
Read leaflet from Pharmacist	58%	54%
Read a drug information column in a magazine	47%	47%
Read a periodic newsletter about drugs	41%	40%
Call a toll-free (800) number of a drug information center	33%	28%
Ask Nurse or other health professional	29%	24%
Buy book about medicines	28%	23%
Attend a discussion meeting about drugs	24%	21%
Ask friends or relatives	16%	14%

Do Older Americans Share These Same Preferences?

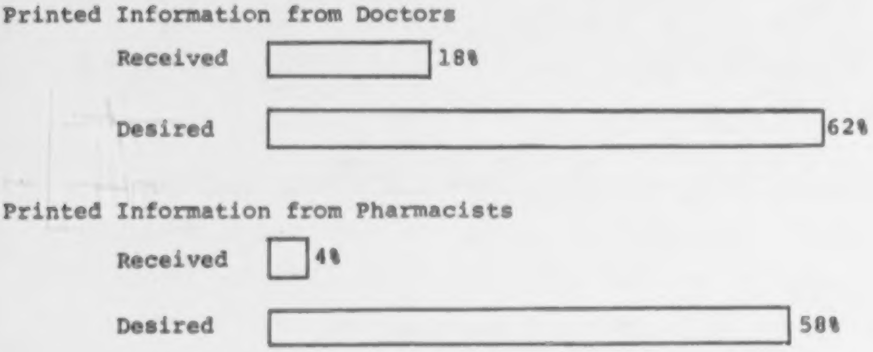
For the most part consumers 65 and over agree with the general public's preferences for action they would take if they wanted more information about a prescription drug. Older Americans have a slightly stronger preference than others to ask their doctors for additional information. For all other suggested options, the elderly were only slightly less likely to use them to fill their information needs.

Consumers Say They Want Leaflets -- Are They Getting Them?

The surveyed public says that the most useful, appealing way for them to get the information about prescription drugs which doctors and pharmacists do not always give them is from printed leaflets. These leaflets or patient package inserts, as they are called, are currently required for only a very few prescription drugs. For the most part consumers are not getting accurate, thoroughly informative, non-promotional information inserts with their drugs. Only 18% of the respondents reported that their doctors always give them printed information. Eighty-three percent said their pharmacists never hand them any printed information. Only 4% said they always could count on their druggist to give some printed information beyond what appears on the prescription bottle. Table 2-6 contrasts consumers' desire to have information provided by leaflets with the quantity of printed information currently being received.

Table 2-6

Consumer Preference for Printed Information --
Present Quantity Received Compared to Quantity Desired



What Characteristics Do These Consumers Who Want Leaflets Share?

This group of respondents who desire printed leaflets from their doctor or pharmacist are fairly equally distributed across the three age brackets. They tend to have slightly more education and income than those not interested in printed leaflets. These consumers want information, but they do not routinely ask questions of either physicians or pharmacists. Of the group of respondents who said they never ask questions, 62% said they would read a printed leaflet from the doctor and 57% said they would use one given by the pharmacist. This subgroup closely mirrors the general public in percentages of people interested in having patient package inserts.

Consumers Say They Want Patient Inserts, but Are They Willing to Pay for Them?

Printing information could increase the cost of drugs. But several recent studies estimate costs to be a matter of pennies.

When asked specifically how much they wanted to pay per prescription, respondents said they are willing to pay the estimated cost of patient package inserts. A very large majority, almost three out of four respondents (73%), would pay up to five cents per prescription, enough to cover the cost of the inserts. Interestingly, the less money consumers make, the more willing they are to pay for information. Almost three out of four respondents (74%) with incomes of only $10,000 or less want to pay this reasonable price of up to five cents for the patient package inserts, compared with 67% of those with incomes of $20,000 or more.

In spite of lower incomes and more drug use, the elderly appear to be as willing as the rest of the public to pay the increased costs of printed leaflets. Table 2-7 illustrates what amount consumers are willing to pay to get information about prescription drugs.

Table 2-7

Consumer Willingness to Pay for Patient Package Insert Costs
(All Consumers Compared to Those 65 and Over)

Cost	All Consumers	65 and Over
0-5 cents	73%	74%
6-10 cents	4	5
11-30 cents	4	4
31-50 cents	7	4
more than 50 cents	9	9

ECONOMIC CONSIDERATIONS IN PRESCRIPTION DRUG USE

Summary

Older Americans' prescription drug costs, amounting to nearly $4 billion in 1981, are unduly burdensome to many. And each year costs increase, for all consumers. The high price of prescription drugs is regarded by a majority of the public as a problem which needs action -- they support two extraordinary measures to help individuals with prescription drug costs.

First, approximately 70% of the respondents 65 years and older and 80% of the surveyed citizens above age 45 want to see the government provide prescription drugs at low or no cost to the elderly. A larger majority supports this kind of assistance for poverty-level consumers. Second, 52% of the public believes there should be an annual limit on the amount an individual should have to pay out-of-pocket for prescription drugs.

Although much of the public knows about less expensive generic drugs, 60% of these people report they never try to buy them. The public knows the basic facts about generics, but significant numbers are unsure if generics have the same standards for quality and safety required of brand name drugs. This uncertainty may account for low usage of generics. Less than a third of the respondents indicate that their doctor or pharmacist told them about generics.

What Solutions to the High Cost of Drugs Do Consumers Support?

The high cost of drugs has been a concern to AARP members for many years. Respondents were asked to register their opinions on two measures to help alleviate the burden of these costs.

The surveyed public realizes prescription drug expenses can be very difficult for the elderly. In 1981 older Americans paid over $3 1/2 billion for prescription drugs with more than 80% of those costs paid out-of-pocket. When asked if the government should provide prescription drugs at low or no cost to the elderly, 76% of the respondents said yes. Close to three-fourths (72%) of the elderly also supported this idea.

An even larger majority believes the government should provide prescription drugs at low or no cost to people living below the poverty level. An awareness that the cost of drugs is unbearable for the truly poor is very strong. A large majority of over 80% believe the poverty-level consumer should receive drugs subsidized or paid for entirely by the government.

Another cost-alternative to prescription drug expenses is supported by a smaller majority of respondents. Fifty-two percent believe that drug costs are sufficiently burdensome to justify an annual limit on how much any one should have to pay out-of-pocket for prescription drugs. Older Americans are slightly more (54%) supportive of this concept than other age groups. As might be expected, consumers earning lesser amounts of money are most in favor of an annual limit on costs, but 41% of the respondents with incomes over $20,000 also believe a cap on costs for individuals is needed.

How Widespread is Knowledge About Generics?

A majority (60%) of all consumers surveyed claimed they are familiar with the term "generic" and know what a generic drug is. Elderly consumers, however, are markedly less informed (53%) than middle-age respondents (69%). In fact, the respondent who knows about generic drugs is likely to be young (45 to 54 years old), white, educated, and earning over $20,000 annually.

These informed people know several important facts. When asked to verify the accuracy of several statements about generics, almost everyone (94%) familiar with generics knew they are usually less expensive than brand name drugs. Similarly a very strong majority of the informed (83%) knew generics are identified by the official chemical name of the drug rather than the brand name. Many (66%) even knew that generics usually are not made by small drug companies.

However, a significant percentage of this subgroup of informed respondents is misinformed on two facts. They do not know generics are required by federal standards to be as safe and effective as brand name drugs. First, 19% of this group of respondents incorrectly thinks brand name drugs are required by the Food and Drug Administration to meet higher standards than generics. In addition, of those who believe they know about generics, 7% stated they do not know if standards are equally high for generics as for brand name drugs. Second, 25% of these respondents think only a few generics have been found by the Food and Drug Administration to be equivalent to brand name drugs.

Where Do Consumers Learn About Generics?

As might be expected, more generic-knowledgeable respondents (32%) agreed they learned about generic drugs from their doctor than from any other source. Older people have a slightly higher tendency than others to rely upon the doctor rather than on other sources for generic drug information. However, doctors convey generic drug information far less frequently than they do information about general health and brand name prescription drugs. (Compare Table 3 with Table 2-1.) Pharmacists are the second most common supplier of generic drug information (26%). Newspapers (23%), books (19%), and television (16%), rank third, fourth, and fifth in this list of sources of information, and that order holds true for all older respondents as well as those in other age groups. Table 3 ranks the principal sources of information about generics for respondents who are knowledgeable about these drugs.

Table 3

Sources of Information about Generic Drugs for Consumers Knowledgeable about Generics

(BASE = 602 Respondents)

(All Respondents Compared to 65 and Over)

Source	All Respondents	65 and Over
Doctors	32%	34%
Pharmacists	26	25
Newspapers	23	22
Books	19	15
TV	16	10
Magazines	13	9
Friends & Relatives	6	7
Other health Professionals	2	2

How Regularly Do Consumers Buy Generics?

In spite of the cost-savings, consumers are reluctant to ask for and use generic drugs when they are available. A solid majority (58%) of the respondents who are knowledgeable about generics admitted they do not try to buy generics when they can. It is the better educated, generic-knowledgeable respondents who are more likely to try to purchase generic drugs.

In general consumers are not aggressive about making sure they receive generic rather than brand name drugs. In spite of the fact that 42% who know about generics said they try to buy generics whenever they can, when questioned more closely, only 24% of those knowledgeable say they always or sometimes ask their doctor to write prescriptions generically and only 21% always or sometimes ask their pharmacists to fill their prescriptions generically. The strong reluctance of respondents who know generic drugs are available and less expensive to use is revealed when 76% of these respondents admitted they never ask their doctors or pharmacists to write or fill prescriptions using generic drugs.

What Characteristics Distinguish Consumers Who Buy Generics from the Rest of the Public?

The educational level of respondents who answered they always try to buy generics or ask their doctor or pharmacists to give them generics is often high. Approximately twice as many respondents who have some college background seek out and use generics as compared to high-school-trained-only respondents.

Similarly, respondents who make the most money, at least $20,000 annually, are far more likely to try to use the economical generic drugs. Close to half (47%) of the generic-knowledgeable respondents who earn over $20,000 try to buy generics while only one-third (33%) of those earning under $10,000 try to do so.

CONSUMER ATTITUDES TOWARD HEALTH AND PRESCRIPTION DRUGS

Summary

This section looks at some of the attitudes of consumers toward prescription drugs. The results are included here to provide general information on the group of consumers interviewed.

The surveyed public is relatively moderate in its prescription drug usage. Only one out of two people takes a doctor-ordered drug. Older Americans, however, take more prescriptions, but use fewer over-the-counter drugs than do other consumers.

Respondents express some ambivalence in their attitude toward prescription drug usage. 79% think we are an over-medicated society, yet 81% believe that they, personally, do not take too many drugs.

The lack of confidence in prescription drug safety and quality is high. A majority, 58%, believe there currently are unsafe drugs on the market. Another third of the respondents think drugs vary in quality between companies.

How Do the People of This Survey Evaluate Their Health?

Many respondents think of themselves as healthy. A large majority of those surveyed (69%) claimed to possess good health. Combined with the 26% who say they are in fair health, 94% of all respondents believe their health is not bad.

As might be expected, perceived good health is not possessed equally by people of all ages. Although a majority of elderly people (62%) rate themselves as healthy, a much larger percentage of middle-age people (78%) believe they are in good health. See Table 4-1 to compare the self-assessed health status in different age brackets.

Table 4-1

Perceived Health Status of Respondents by Age

	CONDITION		
	GOOD	FAIR	POOR
Total Respondents	69%	26%	6%
Middle Age 45-54	78%	18%	4%
55-64	67%	28%	6%
Elderly (65 & over)	62%	30%	8%

In another question asking consumers to list their major health problems, 47%, almost half of all respondents, reported they have no major health problems. As might be expected, fewer people 65 and over claim no major problems. Only 36% percent of the elderly respondents, as compared to 59% of those in the middle age bracket, have no significant health problem.

What Are the Leading Major Health Problems of these Respondents?

When those surveyed do suffer from a major health problem, the four most frequently mentioned illnesses are high blood pressure (18%), arthritis (12%), heart condition (10%), and diabetes (6%). Table 4-2 lists these most commonly-cited health problems and contrasts the frequency with which they occur for all respondents with those in the older age bracket.

Table 4-2

Leading Major Health Problems
for Respondents
with Age Comparisons

HEALTH PROBLEMS	ALL RESPONDENTS	65 AND OVER
None	47%	36%
Heart Condition	10%	16%
High Blood Pressure	18%	19%
Diabetes	6%	8%
Arthritis	12%	16%
Backache	4%	5%
Respiratory Problems	2%	5%
Cancer (all types)	2%	3%

Do Consumers Take Many Drugs to Relieve These Problems?

The drug-taking patterns of those questioned reveal a fairly moderate use of all drugs. As set out in Chapter 1 on prescription drug patterns, slightly more than half of all people over 45 (55%) take one or more prescription drugs regularly. The highest concentration of drug usage occurs with older people, 24% of whom take three or more prescription drugs on a regular basis, compared to only 9% of all middle-age persons taking three or more drugs.

These same moderate-use patterns hold true for non-prescription drugs as well. Consumers were asked how many different varieties of the same type of common over-the-counter drugs they keep on hand at home. For five different remedies, a strong plurality indicated they had no drug on hand whatsoever. Of those who did have the non-prescription drugs in their house, few had more than one variety of that remedy. Table 4-3 indicates how many people had what number of non-prescription drugs in their homes.

Table 4-3

Amounts of Non-Prescription Drug Remedies
Kept in Consumers' Homes

	None	One	Two	Three
Pain Relievers	26%	56%	14%	3%
Upset Stomach Relievers	48%	37%	9%	3%
Cough/Cold Remedies	54%	37%	7%	2%
Vitamins	46%	31%	9%	6%
Laxatives	69%	28%	3%	1%

In addition to non-prescription drugs in the house, consumers say they do not keep a large supply of old prescriptions around the house to have for personal use. 66% said they have no old doctor-ordered medicine at home to take when needed. However, 18% said they have kept one old prescription at home and 9% admitted they have two such drugs on hand.

How Much Do These Respondents Value Their Health?

The general good health and moderate use of drugs by those surveyed do not seem to be mere coincidence. These Americans said that they appreciate their good health and want to keep it. More than three out of four (79%) of all respondents over 45 years old rated themselves either "very concerned" or "somewhat concerned" about health. While this concern is fairly evenly distributed across age and sex groups, non-whites are more likely to be very concerned about their health by a 4:3 (63%:44%) ratio than are whites.

Many respondents feel more than concerned about health -- they feel responsible for their good health. Approximately 75% of all respondents believe good health results from taking care of oneself. This strong majority, nonetheless, is offset by one out of five people (21%) who believe good health is most often a matter of being born with it, 13% who attribute it to being lucky, and 12% who believe good health results from having good medical care.

What Do Consumers Think About Our Level of Prescription Drug Usage?

These generally strong concerns and feelings of responsibility are complemented by the widely-held belief of a majority of men and women questioned that our society takes too many drugs. This opinion is shared by consumers at all levels of education, although, of those with college training, 84% believe we are over-medicated while a slightly smaller majority (77%) of the respondents with only some high school education hold this opinion. Ironically, 76% of those who borrow and lend drugs and 76% of all respondents who claim to be "not at all concerned" about health nonetheless believe most people take too many drugs. Even 72% of the respondents who take a heavy degree of medication and 81% of those who have two or more major health problems hold the firm opinion that most people take too many drugs.

On the other hand, a strong majority of these respondents (81%) believe that they, individually, are not excessive in their prescription drug usage, i.e., they do not take too many drugs. Table 4-4 sets out the numbers of respondents who hold these attitudes on the quantity of consumption of drugs.

Table 4-4

Attitudes Held by Respondents Toward Drug Consumption By Others and Themselves.

	"Most People"	"You"
Take too Many	79%	6%
Take too Few	2	11
About Right	13	81

These opinions are held in equal numbers by all ages of respondents from 45 years and up.

What Is the Level of Consumer Confidence in Drug Quality and Safety?

Respondents are fairly skeptical about the safety and quality of prescription drugs. A solid majority of those asked (58%) believe there currently are available in the United States drugs which are unsafe and one out of four respondents (29%) believe there are differences in quality among prescription drugs made by different companies.

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MOUNTAIN BELL AUDIT
OF MAIL SERVICE
PRESCRIPTION DRUG PROGRAM

WILLIAM M.
MERCER-Meidinger-Hansen

JULY 8, 1987

WILLIAM M.
MERCER-Meidinger-Hansen
INCORPORATED

July 8, 1987

Mr. Paul Tracy
Staff Manager
Mountain Bell
1801 California, Room 1140
Denver, Colorado 80202

Dear Paul:

We are pleased to present a comprehensive audit of the Mountain Bell Prescription Drug Program.

In the following report, we have provided the findings from the on-site visit to National Pharmacies, Inc., in Las Vegas, Nevada, the week of June 8, 1987, and subsequent review of the materials generated by this visit.

If after reviewing this report you need additional material or clarification, please do not hesitate to contact us. We are looking forward to reviewing this report with you on July 8, 1987.

Sincerely,

Linda Miller
Linda Miller
Audit Manager

Diane Messamore
Diane Messamore
Consultant

DM:jev/0052R
20187-335-228

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I. Background

Scope

The scope of the Mountain Bell Prescription Mail Service Drug Program audit included a review of the following:

Contract Compliance

The contract between Mountain Bell and National Pharmacies, Inc., was reviewed to determine if benefits are being paid per the contract and if the contract is complete.

Utilization Review

The utilization review checked for the appropriateness of supply dispensed, possible fraud, and review of medical guidelines followed by National Pharmacies, Inc., for possible contradictions.

Brand-Name vs. Generic Prescriptions

To determine if generic drugs are being dispensed whenever possible, the audit reviewed the number of brand-name only prescriptions written and filled; generic-only prescriptions written and filled; brand name-prescriptions dispensed where generic could have been substituted; and "open" prescriptions where either a brand name or generic could have been dispensed.

Quality Control

The audit assessed error rates, number of refills available, accuracy of fees, and methods of handling Class II narcotics.

Turnaround Time

The original proposal stated that turnaround from the date the prescription was received by National Pharmacies, Inc., would be determined. For reasons discussed later in this report, the audit was unable to verify turnaround time.

Methodology

The on-site audit was conducted during the week of June 8, 1987, by a team of two registered nurses in the Las Vegas, Nevada, office of National Pharmacies, Inc. This is the location which dispenses the Mountain Bell prescriptions.

The audit randomly sampled 214 prescriptions from the monthly listing Mountain Bell received from National Pharmacies, Inc., for January, February, and March, 1987. Based on the sample size of 214 prescriptions, a confidence level of 95% can be placed in the findings, according to the Handbook of Accounting and Auditing by Herbert Arkin.

Description of the Mail-Service Prescription Program

The National Pharmacies, Inc., (National Rx) program requires that Mountain Bell employees or their dependents mail the prescription(s) they receive from their provider(s) to the National Pharmacies facility in Las Vegas to be filled. The Mountain Bell member is instructed to insert the prescription form(s) from their physician in a preaddressed envelope imprinted with Mountain Bell's name, along with the $3.00 coinsurance required for each prescription. Upon receipt by National Rx, each individual's prescriptions are placed in its own container ("pan"), and the amount of coinsurance received is checked for accuracy against the number of prescriptions received. Should a member fail to include the correct amount for coinsurance, the prescription is dispensed anyway, and a note is sent to the member asking for the additional amount. If necessary, a second reminder is sent to the member to collect the appropriate coinsurance. A prescription will never be held pending payment of the correct coinsurance amount.

All prescriptions are screened for entry by a registered pharmacist. This screening includes noting the drug name, the dosage and number to be dispensed, the number assigned to the drug by Medco in their system, and the number of refills approved, if any. As an added precaution, the number assigned by the Medco system and the method used to dispense their drugs make it difficult to make a mistake and substitute a "look alike" for the drug prescribed. The "pans" then go to the clerical area for entry into the system.

The first check upon entry is to determine if the member is currently eligible for the program. If eligibility is in question, the remaining prescription information is pulled from the regular entry flow and is sent to a customer service representative who will call Mountain Bell for eligibility verification.

Once a prescription is entered into the computer system, the system prints labels, checks for potentially harmful physiological reactions (e.g., to many potassium depleters) and drug interactions, and tracks those prescriptions which are possibly being refilled before what would be considered an appropriate lapse of time.

Information regarding potential drug interactions is compiled from several sources, including Facts and Comparisons, manufacturers' studies, data or reports available, and the Physicians' Desk Reference (PDR). National Rx updates this information on a continual basis as additional data is made available. If one is available, an information sheet about the drug is included by National Rx for the patient's use, particularly if a generic substitution has been made.

Exceptions noted for possible drug interactions or overuse are printed out, and each is checked by a pharmacist before the prescription is routed for filling. The pharmacist checking the exception is not the screening pharmacist; therefore, an additional safety check is provided.

Prescriptions ready for filling are placed on a conveyor which circulates through a dispensing area. Each "station," staffed by a registered pharmacist, has different drugs available to dispense; "look alike" drugs are kept at different stations as a precaution against dispensing the wrong drug. As the pans circulate on the conveyor, each station's pharmacist identifies those prescriptions found in their area and removes the appropriate pan. Before dispensing any medication, the filling pharmacist checks each original prescription form for accuracy against the label.

If there are additional prescriptions to be filled at a different station, the pan is put back on the conveyor and routed. The pharmacist who fills the last prescription is responsible for rechecking all the filled prescriptions in the pan against the original prescriptions before sealing them in a mailing bag. The pharmacist then stamps the mailing bag with their identification number, indicating that they are the pharmacist who completed the order.

The mailing bags are routed to a mailing area for postage and are sorted for post office pickup. Those drugs requiring additional controls, i.e., Class II narcotics, are kept in a locked cage and are dispensed from this secure area. Class II narcotics cannot be shipped through the U.S. mail and are sent by U.P.S. Additional precautions are taken with these drugs. U.P.S. shipping slips are completed, and the filled prescriptions do not leave the secured area until the U.P.S. pickup arrives, at which time a pharmacist(s), security guard, and U.P.S. driver remove the bags and shipping slips from the cage and load them on the truck. These packages require a signature when delivered by U.P.S., and the returned slips are checked by National Rx security against the original shipping record.

If at any time during this entire procedure any of the pharmacists have a question concerning any prescription they are working on, the pharmacist can call the physician to clarify the drug, dosage, quantity, refills available, etc., or verify that the provider is aware of a physiological reaction or potential drug interaction. The pharmacist has the right and responsibility to verify anything he or she does not feel comfortable with just as the pharmacist at the "corner drugstore" would.

National Rx Services attempts to keep the patient informed of refills remaining on a prescription by returning a refill slip and preaddressed envelope with each prescription (the refill slip indicates refills available). If the refill slip indicates zero refills remaining, the patient, obviously, should check with their provider rather than calling to inquire or sending for further refills.

The envelope and refill information is included for the convenience of the patient and is easily identified as a Mountain Bell claimant when received for processing by National Rx Services.

Internal dispensing procedures at National Rx require a phone call to the prescribing physician to verify without exception any prescription for a Class II narcotic, even if the patient has been routinely taking the drug and it has been previously verified.

After observing this system at work, we feel comfortable with the number of quality controls built into the system and the resulting level of accuracy, which we feel is equal to or above that found in many local drug or chain stores. Also to be noted is the fact that at National Rx, the dispensing pharmacist is able to concentrate on his or her task without the distraction of phone calls, customer inquiries, or activities related to prescription pick up or drop off.

II. Findings and Analysis

FRAUD

Eligibility

During our review, we could not check eligibility on the claims in our sample. National Rx Services receives a monthly tape update from Mountain Bell (they check with Mountain Bell on individuals who come up as an exception to verify eligibility for the date of service in question), and these monthly updates nullify date of service records, therefore making it impossible for us to go back and review the system for the date each prescription was received and filled.

However, while on-site, the auditors made an attempt to "beat" the system and enter a prescription for a non-Mountain Bell member. It was unsuccessful, as eligibility is the first edit.

After reviewing National's processing procedures and attempting to "beat" the system, we feel comfortable that National Rx is accurately identifying eligible Mountain Bell claimants.

Prescription Fraud

We found no evidence of fraud by either National Pharmacies, Inc., or Mountain Bell subscribers during our review of the 214 prescriptions in our random sample. However, one prescription for a Mountain Bell dependent, received while we were on site, was brought to our attention by National Rx.

While doing a routine screening before entering a prescription, the pharmacist noticed that a digit specifying drug quantity was written in a shade of ink slightly darker than the rest of the prescription. The pharmacist called the provider to verify the quantity prescribed and discovered that the prescription had been altered. The provider asked that the altered prescription be returned. National Rx returned only the altered prescription and processed as written the additional prescription received in the same mailing. We subsequently reviewed this dependent's entire prescription record, but found nothing else of a suspicious nature.

We feel the entry and filling procedures used by National Rx Services are designed to decrease and/or uncover most incidences of fraud or possible fraud. The Medco system alerts the pharmacist if a prescription for a drug is being filled or refilled too frequently, even if the prescription is for different members of the same family. As prescribing providers are routinely called to verify all prescriptions for Class II narcotics, the above case involving a Class II narcotic would have been discovered even if the pharmacist had not detected a difference in ink shade.

A call to the provider on all Class II narcotics is an additional safeguard for both patient and Mountain Bell, and National Rx should be commended for this policy.

Contract Compliance and Quality

During our review of the random sample, we found the guidelines of the contract were being adhered to and that the supplies being dispensed were appropriate. In fact, in two cases, we found the quantity dispensed was decreased by National Rx on two separate occasions to comply with manufacturers' recommendations. In our opinion, this modification was appropriate as a precautionary measure to protect both physician and patient and is consistent with the high level of accuracy found at National Rx. Their employees are, in our opinion, very professional, and they attempt to remain current in an milieu of constantly changing information.

Prescription fees are calculated by the computer system using the quantity dispensed against the Average Wholesale Price ("AWP"), AWP being the price quoted in the Drug Topics Red Book (or its latest supplement) on the date the order was filled. Red Book AWP data is a nationally accepted source for calculating average wholesale prescription prices.

The system identifies the correct AWP by using the Medco-assigned number based on 100 unit or 16 oz. quantities, unless only smaller quantities are available. National Rx grants Mountain Bell a 13% discount off the AWP for brand-name drug prescriptions and a 20% discount off the AWP for generic-drug prescriptions. Because of the attention given to entering the correct drug number, and since charges (including AWP, postage, coinsurance, and discount percentages) are calculated by the system, errors in fee calculations do not occur.

The one payment error we did identify resulted because a prescription record was entered twice, not because the fee was calculated incorrectly. In this case, a corrected prescription record was entered onto the system. The original record was not deleted. The prescription was not filled twice, as the original error was detected before this point in the process. National Rx, after our inquiry into the case, has initiated a credit to Mountain Bell.

Brand-Name vs. Generic Prescriptions

National Rx has a coding system which identifies each drug and its potential for substitution with a generic. The prescription drugs, identified as "A's" by National Rx Services, are brand-name drugs that do not have a bioequivalent (generic) available and/or are included on a directive from the Nevada State Board of Pharmacy as not legal substitutions. Drugs in this category are excluded from potential savings resulting from generic substitutions.

Prescription drugs identified as "B's" by National Rx Services are lrand-name drugs for which there is a bioequivalent (generic) available. National Rx does attempt to substitute the generic if it is less expensive than the brand name. However, a generic substitution cannot be made in the following cases:

- The drug is included on a directive from the Nevada State Board of Pharmacy which lists those drugs not eligible for consideration in making a generic substitution,;
- The drug is not FDA approved for substitution;
- The drug manufacturer or wholesaler is not licensed in Nevada;
- The provider does not authorize a generic substitution;
- The patient does not authorize substitution by signature, even if substitution is allowed by the provider. This occurs in one of two ways:
    1. The patient does not sign the authorization line on the Mountain Bell envelope form, and/or
    2. The prescriptions are sent to National Rx Services in a "plain white envelope," rather than the preaddressed envelope which has a line for the member to sign to authorize generic substitution.

Prescription drugs in Category B represent an area where cost savings can be both claimed and potentially increased. We recommend a plan educating Mountain Bell employees, their dependents, and providers to request and use more generic drugs if therapeutically equivalent and available. Although providers and patients should never be forced to use a generic, they should be encouraged to do so and be shown how the cost savings or lack thereof could impact them and/or Mountain Bell and the benefits it is able to offer and maintain. Rising health-care related costs affect everyone.

- - -

Generic drugs are identified by National Rx Services by a "G." These drugs usually represent a more cost-effective alternative than their brand-name equivalents; however, the difference in price cannot be considered savings unless the original prescription was written for a brand name, and a generic substitution was made. If the original prescription was written for generic, what can be shown in lieu of savings is what the maximum potential cost liability would have been had a brand name drug been used instead; but it would be erroneous for either National Rx or Mountain Bell to reflect these figures as savings.

Our review of the 214 prescriptions in the random sample revealed:

	Category				
	A	B Filled Brand Name	B Filled Generic	G	Total
Original	68	19	11	8	106
Refills	80	15	7	6	108
Total	148	34	18	14	214

Cost Savings

In the following cost-savings analysis, we show the breakdown of how the physicians wrote their prescriptions and whether they would have allowed a generic substitution. In some cases, a substitution was not possible because of Nevada State Board of Pharmacy regulations. In other cases, substitutions could not be made, apparently, because the member either did not authorize a substitution, or the request was received in a "white envelope." The National Rx system is designed to identify any drug for which a generic equivalent is available, and if available, the pharmacist will check the prescription for authorization to substitute a generic.

Definition of Terms

No: Physician will not authorize generic substitution; must be filled as written.

Yes: Physician gives his authorization for generic substitution.

Open: Physician did not specify "Yes" or "No"; therefore, under Nevada regulations, this is considered an implied consent for substitution.

Not Applicable: Insulin syringes, monlet lancer.

Brand-Name Cost: Cost if all prescriptions were filled with brand-name drugs.

Can't Substitute: Under regulations passed by the Nevada State Board of Pharmacy, these drugs cannot be substituted but must be filled as written.

Generic Cost: The cost if all prescriptions which had generic available were filled as generic.

Savings: Actual savings Mountain Bell realized or potential savings Mountain Bell could have realized when generic substitutions were available.

Potential Additional Liability: The total dollar amount Mountain Bell would have been liable for if prescriptions had been filled with a brand name.

Category A Drug

Prescription written and filled as a brand-name drug (no generic exists)

	Original	Refill	Total
No	19	24	43
Yes	21	18	39
Open	26	37	63
Not Applicable	2	1	3
Total Prescriptions	68	80	148
Brand-Name Cost			$4,733.67

Category B Drug

Prescription written and filled as a brand-name drug (generic exists)

	Original	Refill	Total
No	10	5	15
Yes	3	6	9
Can't	3	0	3
Open	1	2	3
Can't	2	2	4
Total Prescriptions	19	15	34
Brand-Name Cost	$603.38	$402.18	$1,005.56
Can't Substitute	$133.90	$32.50	$ 166.40
Generic Cost	$149.47	$179.08	$ 328.55
Potential Savings	$453.91	$223.10	$ 677.01

Prescription written as brand name, generic substitution made

	Original	Refill	Total
No	0	0	0
Yes	6	5	11
Open	5	2	7
Total Prescriptions	11	7	18
Brand-Name Cost	$324.34	$198.32	$522.66
Generic Cost	$ 97.76	$ 47.00	$144.76
Actual Savings	$226.58	$151.32	$377.90

Category G Drug

Prescriptions written and filled as generic

	Original	Refill	Total
No	1	1	2
Yes	6	4	10
Open	1	1	2
Total Prescriptions	8	6	14
Brand-Name Cost	$184.22	$68.51	$252.73
Generic Cost	$ 68.59	$36.35	$104.94
Potential Additional Liability	$115.63	$32.16	$147.79

Turnaround Time

Mountain Bell's agreement with National Rx Services states, on Page 2, Number 5, "...National will process all prescriptions immediately upon request and in the usual course deposit them in the mail within forty-eight (48) hours, addressed to the appropriate eligible person."

During our on-site review, we were unable to verify the turnaround time of our sample. The prescriptions do not receive a notation or date stamp either when received or mailed out. This does not appear to be an area of concern at this time. After observing their operational procedures, we feel comfortable that National Rx is maintaining the 48-hour turnaround in most cases. We discussed the inability to verify turnaround time with Mr. Howard Weisman, Manager; and Mr. Roger Williams, Managing Supervisor of National Rx Services.

We recommend that Mountain Bell monitor turnaround time and be aware of any employee complaints regarding turnaround or delay of prescriptions.

Mountain Bell may wish to discuss the date stamp issue with National Rx Services and require that that procedure or a similar one be adapted.

III. Conclusion

In conclusion, we feel Mountain Bell's current program with National Pharmacies, Inc., is meeting the needs of its employees and dependents. National Rx appears to be using sound medical guidelines and numerous safety and quality checks to assure Mountain Bell of a quality program. The National Rx employees we met conducted themselves in a courteous, professional, and knowledgable manner. They were very willing to help us, answer questions, and assist in the review of our randomly selected Mountain Bell prescriptions.

Our one concern is whether it is necessary for Mountain Bell to use a mail-service program for its members in an effort to save on a prescription program . We suggest investigating the possibility of using a regionally located outlet, e.g., Target, K-Mart, Walgreens, Osco, etc., and negotiating a discount agreement with them. This would eliminate turnaround and postage considerations (no matter how minimal) inherent in a mail-service program. The coinsurance program could remain intact and members could be identified, for example, by a membership number or card, although this would not necessarily have to be a prescription card program.

No matter what program Mountain Bell uses for their prescription drugs, additional savings could be realized if more physicians prescribed, and patients authorized, the use of generic equivalents. We suggest, in an effort to increase savings, implementation of an aggressive education campaign targeted at both the physician and the member emphasizing the cost-saving benefits of using generic drugs, while maintaining that the pharmaceutical benefits should remain unchanged. We again stress that as generics are not available for all drugs, and that some generic and brand-name drugs are not interchangeable, the program must leave intact the option to prescribe brand-name drugs.

Summary of Audit Findings:

1.	Total number of prescriptions examined:	214
2.	Total dollar amount represented in the prescriptions examined:	$5,988.93
3.	Total number of prescriptions with dollar errors:	1
4.	Total number of prescriptions with errors:	3
5.	Total dollar amount (in absolute values) represented in the prescriptions with errors:	$33.51
6.	Error rate in dollars (#5 divided by #2):	.6%
7.	Occurrence error rate - dollar errors:	.5%
	- statistical/processing errors:	.9%
	Total errors	1.4%

Error Statistics

PAYMENT ERRORS

Claim Statistics	Comments
# 132 Contract No.: 155-58-4969 Rx No.: 3524257 Date of Service: 03/09/87 Overpaid: $33.51 (?)	While reviewing this record, we found an error which had resulted in Mountain Bell paying twice for the same prescription. When the original prescription was first entered onto the system, the drug code was entered incorrectly. The error was caught before the prescription was filled, and a change was entered under a new prescription number; however, the original number was not voided, and Mountain Bell was billed for two prescriptions. After our inquiry, National Rx Services asked their New Jersey office to issue a credit to Mountain Bell for the amount of the duplicate prescription. Although the Nevada office was unable to give us the exact credit amount, we believe it to be about $33.51. This error also resulted in the refill slip incorrectly advising the patient of the number of refills available on the prescription. However, National has since written a letter to the patient clarifying the situation.

PROCESSING AND/OR STATISTICAL ERRORS

Claim Statistics	Comments
#43	
Contract No.: 526-36-0544 Rx No.: 0214822 Date of Service: 01/21/87	Two processing and/or statistical errors occurred on this prescription. First, the quantity of drug ordered was screened and dispensed incorrectly as 100 tablets rather than the 180 tablets written. The patient has not had a refill or new script for this drug since the date of service on this claim number; therefore, no additional expense resulted from this error. Secondly, a math error occurred when calculating the length of the prescription's supply for data entry onto their system. The supply should have been noted as 130 days, not 180 days. This error, however, in no way affected charges to either the patient or Mountain Bell, nor did it determine whether a future prescription would be considered. National Rx uses the prescription supply data on their system to help them determine if a prescription is being refilled too soon. If so, they will reject it for further investigation.
77	
ontract No.: 504-60-8674 x No.: 0515315 ate of Service: 02/20/87	While reviewing the history for this drug, we found that subsequent to the January 21, 1987, prescription we were auditing, new prescriptions were received and filled on April 17 and May 4, 1987. The one filled on May 4 should have been questioned, as this submission was too close to the prior prescription date.

Claim Statistics	Comments
#77 (continued)	Both the April 17 and May 4 scripts were for 25 mg. dosages, although the patient record indicates that 12.5 mg and 25 mg. have been prescribed in the past. This could have created some confusion. Although the drug prescribed is not an abuse drug, it should have been rejected for investigation. However, no additional dollars were "wasted" by Mountain Bell on this claim.

FINDINGS

Claim Statistics	Comments
#28 Contract No.: 521-07-0610 Rx No.: 2944687 Date of Service: 01/06/87 #171 Contract No.: 521-07-0938 Rx No.: 3162222 Date of Service: 03/03/87	In each of these cases, the provider had written the prescription for 100 tablets dispensed. Because the manufacturer, in the Physicians' Desk Reference (PDR), warns against dispensing more than 30 tablets at a time, National Rx only filled the prescription for 30. Although the prescription filled was inconsistent with the number ordered by the provider, National Rx did provide an explanation to the patient. We certainly consider this careful scrutiny of manufacturer recommendations to be an added benefit in protecting both patient and provider.
#41 Contract No.: 525-66-8947 Rx No.: 0051644 Date of Service: 01/05/87	Plaquenil Tabs have been identified as a Category A drug, indicating a generic substitution is not available. However, Roger Williams, of National Rx, explained that Plaquenil is considered an "orphan" drug, in that while a generic is indicated in the PDR source book for this seldom-used drug, no one makes it anymore. Therefore, Plaquenil falls into the A category.

Claim Statistics	Comments
#121 Contract No.: 529-24-7818 Rx No.: 0346692 Date of Service: 02/03/87	Rufen 800 mg. was ordered by the provider, but this brand is not currently available in an 800 mg dosage. National Rx therefore substituted a different bioequivalent brand, Motrin, in the prescribed dosage. A generic substitution could not be made because the patient either failed to sign the authorization or the prescription was received in a "white envelope." The provider, however, did imply his consent by not taking an active role in requiring that it be filled as a brand name. A generic substitution would have resulted in a savings of $38.06
#130 Contract No.: 065-24-4184 Rx No.: 0653844 Date of Service: 03/06/87	The provider wrote his prescription for amoxcillin tablets, and ordered a generic drug by name. National Rx had no choice but to fill this with a brand name, as Amoxcil is the only tablet form of this drug available. National could have called the doctor to verify his preference for a tablet instead of a capsule, but it was felt the prescription was "sound" as written, and that a call to verify intention might have been resented. National Rx's decision in this case is considered an exception, as they do attempt to use generic whenever possible. We agree that Mountain Bell would not want to risk good relations with a provider. Having named a generic, this provider is no doubt already aware of the cost-saving impact of prescribing them, and we assume the physician will continue to do so in the future.

Master List of Audited Prescriptions

25-Jun-87

MASTER LIST

M-M-H CLAIM NO. CLAIM NO.	SS NO NO	PRESCRIP NO NO	DATE OF SERVICE SERVICE	TYPE OF DRUG DRUG	CHG TO MTN BELL MTN BELL	BRAND PRICE PRICE	SAVINGS SAVINGS
3	223421567	3354526	01-03-87	G	3.40	6.66	3.26
59	094421525	3292504	02-13-87	G	1.83	8.83	7.00
60	159200698	0414405	02-10-87	G	5.50	10.76	5.26
61	218447308	2344985	02-13-87	G	2.77	7.18	4.41
73	474325385	0383563	02-07-87	G	2.91	4.60	1.69
80	516229398	3148988	01-31-87	G	1.15	11.91	10.76
87	519096062	0321057	02-01-87	G	19.75	51.24	31.49
108	525661844	27335508	02-03-87	G	13.75	13.75	0.00
112	527105998	0314894	01-31-87	G	3.40	43.07	39.67
122	529422830	1575004	02-11-87	G	13.45	20.18	6.73
144	450364534	08	03-05-87	G	7.85	18.52	10.67
~~184~~	~~524207165~~	~~0623587~~	~~03-03-87~~	~~G~~	~~2.73~~	~~2.73~~	0.00
185	524283208	0798194	03-20-87	G	1.09	2.56	1.47
205	529245931	0827746	03-23-87	G	25.36	50.74	25.38
~~132~~	~~155584969~~	~~3524257~~	~~03-09-87~~	~~A~~	~~11.33~~		
43	526360544	0214822	01-21-87	A	8.38		
77	504608674	0515315	02-20-87	A	30.27		
~~28~~	~~521070610~~	~~2944687~~	~~01-06-87~~	~~A~~	~~8.75~~		
171	521070988	3162222	03-03-87	A	8.78		
41	525668947	0051644	01-05-87	A	26.68		
~~121~~	~~529247818~~	~~0346692~~	~~02-03-87~~	~~B~~	~~75.98~~	~~37.92~~	38.06
130	065244184	0653844	03-06-87	A	5.45		
124	530187542	0504905	02-19-87	G	33.11	128.98	95.87
~~8~~	~~380304808~~	~~0174831~~	~~01-17-87~~	~~G~~	~~28.15~~	~~48.73~~	20.58
39	524423568	2553260	01-20-87	G	7.79	49.84	42.05
40	525406369	2122595	01-06-87	G	9.25	54.87	45.62
~~76~~	~~497280140~~	~~3494155~~	~~01-29-87~~	~~G~~	11.95	~~30.84~~	18.89
79	514225782	0425077	02-11-87	G	1.13	12.15	11.02
88	519309209	0513611	02-20-87	G	1.87	21.24	19.37
90	520281944	2454792	02-02-87	G	2.20	22.46	20.26
95	521322619	2233315	01-31-87	G	3.65	5.44	1.79
113	527327864	0427379	02-11-87	G	3.89	23.45	19.56
125	540382913	1534773	02-21-87	G	6.25	13.61	7.36
136	305444315	2333651	02-25-87	G	5.91	21.26	15.35
156	516248628	50645089	03-05-87	G	2.35	4.46	2.11
162	518167589	0612447	03-02-87	G	11.95	30.84	18.89
166	517104638	0587058	02-27-87	G	6.20	14.53	8.33
175	521466428	0854366		G	4.93	12.49	7.56
195	527030943	0684475	03-09-87	G	3.39	20.92	17.53
206	529407128	0645085	03-05-87	G	0.79	6.55	5.76
5	307107815	0412167	12-30-86	B	23.66	12.13	11.53
10	446030120	0033119	01-03-87	B	4.87	1.93	2.94
12	474345390	0216656	01-21-87	B	56.17	22.75	33.42
15	505167371	0061733	01-06-87	B	92.02	12.11	79.91
30	521348803	2614494	01-23-87	B	9.75	5.41	4.34
36	523427404	3234664	01-22-87	B	27.20	0.00	0.00
45	527264201	1133165	01-15-87	B	51.43	15.27	36.16
54	538228029	0243512	01-24-87	B	28.70	3.40	25.30
55	548721846	3633348	12-29-86	B	27.20	0.00	0.00
62	268240344	0446842	02-13-87	B	142.49	32.52	109.97

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MASTER LIST

M-M-H CLAIM NO.	SS NO"	PRESCRIP NO	DATE OF SERVICE	TYPE OF DRUG	CHG TO MTN BELL	BRAND PRICE	SAVING
74	482144160	0163369	02-06-87	B	95.80	45.11	50.6
78	509058274	0344998	02-03-87	B	26.55	0.00	0.0
82		2103518	02-20-87	B	20.78	9.70	11.0
85	518075136	0373584	02-06-87	B	25.42	3.41	22.0
86	518389580	0433240	02-06-87	B	17.39	6.22	11.1
102	523566455	0416503	02-10-87	B	40.14	4.73	35.4
107	525387863	0311989	01-31-87	B	45.40	0.00	0.0
114	527668702	0282701	01-28-87	B	5.76	2.88	2.8
119	528742926	0292060	01-29-87	B	5.10	2.31	2.7
123	529629518	0074241	02-11-87	B	5.30	0.00	0.0
131	103223346	0645498	03-05-87	B	19.51	2.10	17.4
134	257541116	0856891	03-26-87	B	31.85	8.76	23.0
140	364260393	061616	03-02-87	B	36.96	3.97	32.9
159	517202204	2544107	03-23-87	B	13.70	1.96	11.7
168	520303946	3432446	03-11-87	B	15.31	8.01	7.3
173	521246101	5352409	03-11-87	B	18.74	4.53	14.2
187	524585462	2483939	02-26-87	B	18.69	11.91	6.7
192	526209767	0754690	03-16-87	B	16.75	0.00	0.0
196	527329060	0828041	03-23-87	B	18.00	0.00	0.0
201	528381766	2592248	03-13-87	B	55.80	31.21	24.5
202	528605268	0623471	03-03-87	B	38.41	10.68	27.7
210	553160282	0085325	03-06-87	B	43.25	19.21	24.0
213	578623929	0264056	03-06-87	B	17.88	8.41	9.4
11	458013770	2592872	01-12-87	A	6.37		
13	481345974	0123589	01-12-87	A	87.13		
14	498324208	0214902	01-21-87	A	13.60		
16	511441788	1542149	01-19-87	A	8.49		
17	516032137	1954219	01-09-87	A	5.89		
18	516284728	1321433	01-05-87	A	79.25		
19	516404689	0203126	01-20-87	A	53.69		
20	517241362	1911435	12-29-86	A	142.44		
21	517463550	3642615	12-30-86	A	7.26		
22	518202958	1282799	01-10-87	A	99.63		
23	518367414	0132480	01-13-87	A	22.28		
24	519241855	3253794	01-09-87	A	15.52		
25	519380616	0167075	01-16-87	A	67.31		
26	520202885	2883264	01-12-87	A	5.89		
27	520440868	0024862	01-02-87	A	24.56		
29	521076430	0174556	01-17-87	A	19.74		
31	521660417	2323480	12-31-86	A	34.51		
32	522225568	0192427	01-19-87	A	10.01		
33	522384186	1983263	01-17-87	A	8.38		
34	522888266	0204983	01-20-87	A	32.53		
35	523223131	2233770	01-23-87	A	26.25		
37	524093716	2974845	12-31-86	A	18.43		
38	524307519	0124500	01-12-87	A	21.43		
42	526109494	1344573	01-22-87	A	39.75		
44	526722522	1783033	01-21-87	A	21.73		
46	527685416	0191389	01-19-87	A	17.79		
47	5280[illegible]3410	0065465	01-06-87	A	6.51		
48	528286093	1913256	01-06-87	A	39.71		

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MASTER LIST

M-M-H CLAIM NO.	SS NO	PRESCRIP NO	DATE OF SERVICE	TYPE OF DRUG	CHG TO MTN BELL	BRAND PRICE	SAVINGS
49	528402851	2413639	01-23-87	A	10.18		
50	528726180	1073324	01-09-87	A	48.17		
51	529098317	0061770	01-06-87	A	30.80		
52	529327025	0201275	01-20-87	A	19.74		
53	529580380	0841463	01-23-87	A	33.51		
56	567466079	0093949	01-09-87	A	18.04		
57	585321966	2802426	01-07-87	A	9.09		
58	053440111	0502712	02-19-87	A	3.68		
63	292200481	0383394	02-07-87	A	13.80		
64	317304817	0504902	02-19-87	A	27.12		
65	332183924	0496684	02-18-87	A	12.27		
66	351421151	0504099	02-19-87	A	13.95		
67	366051115	1395683	02-20-87	A	7.65		
68	396072572	1134526	02-06-87	A	13.60		
69	426807343	0504168	02-19-87	A	12.27		
~~70~~	~~449427489~~	~~3432554~~	~~02-09-87~~	~~A~~	~~39.75~~		
71	455446331	3571679	02-10-87	A	28.12		
72	465341271	2473782	12-07-87	A	6.45		
75	485520312	0363424	02-05-87	A	12.98		
81	516320220	1752566	01-26-87	A	23.64		
83	517245683	0515256	02-20-87	A	33.19		
~~84~~	~~517568653~~	~~3232317~~	~~02-03-87~~	~~A~~	~~32.12~~		
1	063106640	3083252	01-08-87	A	46.20		
2	155092627	2024606	01-22-87	A	7.07		
~~4~~	~~284283175~~	~~0051611~~	~~01-05-87~~	~~A~~	~~71.42~~		
6	332403515	1913825	01-06-87	A	27.85		
7	349129256	2273623	01-07-87	A	11.13		
~~9~~	~~413225162~~	~~2881954~~	~~01-07-87~~	~~A~~	~~19.74~~		
89	519526709	0516214	02-20-87	A	17.03		
91	520440868	2824284	01-30-87	A	13.51		
92	521053405	2883641	01-26-87	A	41.70		
93	521071856	1603176	01-31-87	A	23.85		
94	521229193	5125918	02-20-87	A	37.40		
96	521644722	0303759	01-30-87	A	31.38		
97	522147804	52952978	02-11-87	A	19.95		
98	522346843	0337714	02-02-87	A	105.74		
99	522666700	3023148	01-29-87	A	21.10		
100	523141462	0495762	02-18-87	A	54.62		
101	523244910	0346372	02-03-87	A	27.24		
103	524101382	3242338	02-19-87	A	16.48		
104	524286687	3023562	02-09-87	A	19.70		
105	524367295	0520836	02-21-87	A	33.19		
106	525036069	1355387	01-26-87	A	41.30		
109	526013071	0496727	02-18-87	A	9.40		
110	526262663	1434607	02-12-87	A	8.75		
111	526486002	1413751	02-18-87	A	135.19		
115	528019198	3281853	02-12-87	A	15.03		
116	528246784	1542153	02-13-87	A	28.49		
117	528322529	0262841	01-26-87	A	14.59		
118	528524535	0366921	02-12-87	A	19.05		
120		03547098	02-04-87	A	49.65		

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MASTER LIST

M-M-H CLAIM NO.	SS NO	PRESCRIP * NO	DATE OF SERVICE	TYPE OF DRUG	CHG TO MTN BELL	BRAND PRICE	SAVINGS
126	555442149	0320904	02-01-87	A	13.60		
127	564988065	0415061	02-10-87	A	140.46		
128	585169614	1133215	02-02-87	A	11.85		
129	010265627	0854357	03-26-87	A	10.26		
133	193327108	3284293	02-25-87	A	39.64		
135	275342265	0716147	03-12-87	A	17.06		
137	316480075	0577066	02-26-87	A	18.18		
138	335365662	0307520	03-12-87	A	18.07		
139	348527558	0544782	02-23-87	A	9.54		
141	376424066	3142737	03-23-87	A	26.74		
142	410366426	50575193	02-26-87	A	17.27		
143	436880963	0320470	03-02-87	A	3.14		
145	453058443	0726337	03-13-87	A	17.12		
146	461822356	1542831	03-23-87	A	1.23		
147	468093542	2544418	03-10-87	A	9.00		
148	479267548	0716709	03-12-87	A	33.73		
149	482329927	0546376	03-02-87	A	29.17		
150	496340810	2795201	03-16-87	A	26.64		
151	503203565	6158228	03-02-87	A	112.01		
152	506427971	0563489	02-25-87	A	40.09		
153	509285778	2333968	03-09-87	A	17.79		
~~154~~	~~514106896~~	~~12229808~~	03-05-87	A	~~54.28~~		
155	516032641	0413547	03-13-87	A	42.03		
157	516306228	0687614	03-09-87	A	49.74		
158	516605045	1352950	03-11-87	A	205.27		
160	517368740	0707681	03-11-87	A	89.32		
161	517640284	0577575	02-26-87	A	89.32		
163	518321598	2934821	03-05-87	A	16.64		
164	519096788	53574241	03-05-87	A	67.94		
165	519247095	1962434	03-18-87	A	26.83		
167	520019112	2043828	03-16-87	A	19.84		
169	520505652	0612238	03-02-70	A	7.26		
170	521052440	0682308	03-09-87	A	40.25		
172	521103364	5350577	03-26-87	A	12.16		
174	521368826	0716145	03-12-87	A	45.73		
176	522141852	2743288	03-27-87	A	24.95		
177		3304636	03-11-87	A	24.49		
178	522406276	0626223	03-03-87	A	31.89		
179	522666590	0777682	03-18-87	A	52.08		
180	523188152	0568400	02-25-87	A	35.33		
181	523283733	2555034	03-05-87	A	24.95		
182	523462689	0796403	03-20-87	A	58.71		
183	523940691	0763334	03-17-87	A	9.01		
186	524367295	0271364	03-24-87	A	14.35		
188	525301212	2622531	02-25-87	A	31.05		
189	525527583	0285852	03-24-87	A	177.00		
190	525748889	2512529	03-16-87	A	13.60		
191	526024454	0548209	02-23-87	A	16.81		
193	526361253	0696976	03-10-87	A	30.27		
194	526668838	0065470	02-24-87	A	20.48		
197	527505422	0695373	03-10-87	A	11.56		

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MASTER LIST

M-M-H CLAIM NO.	SS NO	PRESCRIP NO	DATE OF SERVICE	TYPE OF DRUG	CHG TO MTN BELL	BRAND PRICE	SAVINGS
198	528018948	0763977	03-17-87	A	4.37		
199	528089322	0576946	02-26-87	A	11.97		
200	528282379	0263539	03-20-87	A	100.32		
203	528805804	0588012	02-27-87	A	41.64		
204	529149320	0834285	03-24-87	A	11.23		
207	529605724	0496676	03-11-87	A	17.38		
208	529999866	0716776	03-12-87	A	32.89		
209	543243406	0777620	03-18-87	A	14.06		
211	558265607	1764116	03-26-87	A	27.12		
212	567289310	3453435	03-19-87	A	35.83		
214	722127752	0555784	02-24-87	A	27.74		
		TYPE A CHARGES		146	4733.67	0.00	0.00
		TYPE B CHARGES		34	1171.96	328.55	877.01
		TYPE C CHARGES		32	249.70	775.39	525.69

Evaluation of Consumer Opinions
of
Prescription Drug Services from
Community and Mail Order
Pharmacies

Sponsored
by
Chapman Drug Company

Conducted
by
The Center for Pharmacy Management and Research
The University of Tennessee
College of Pharmacy

Kenneth B. Roberts, MBA, Ph.D.
Principal Investigator

and

Walter L. Fitzgerald, M.S. J.D.
Co-Principal Investigator

June 2, 1986

Center for Pharmacy Management and Research

The Center for Pharmacy Management and Research was established at the University of Tennessee College of Pharmacy in 1985 for the purpose of producing and providing management information for the pharmacy profession and related health care institutions. The Center goals include research in health care management, education for health care practitioners and service to industry, institutions and entrepreneurs in pharmacy. The Center is supported by the College of Pharmacy and endowments established by virtue of gifts from Mr. R. C., "Dudley", Hoskins, D.Ph. of Clinton, Tennessee and Chapman Drug Company of Knoxville, Tennessee.

Evaluation of Consumer Opinions of Prescription Drug Services from Community and Mail Order Pharmacies

Introduction

During the past three years many employers and union trust funds have intensified their search for less expensive alternatives for providing health care benefits. Prescription drug benefits, although representing only 6.7 percent of total health care expenditures, have experienced uncommon scrutiny. Some large corporate purchasers, in search of health care cost containment, have implemented what many providers consider to be bizarre alternative delivery systems. Among such delivery systems are mail order prescription drug programs.

Although mail order prescription programs have only recently made headlines, these programs began in the prescription drug industry over forty years ago. The most famous programs with longevity include the Veterans Administration (VA) Drug Benefit established in 1946 and the National Association of Retired Teachers established in 1959. The VA program, a free service to veterans, mailed 19.3 million prescriptions in the 1983 fiscal year. This was by far the largest mail order program. Other programs met with mixed success until the health care industry entered the era of cost containment. Besides the large VA program, the next two largest mail order providers are the American Association of Retired Persons (AARP), dispensing approximately 5 million prescriptions per year, and National Pharmacies, dispensing approximately 2 million prescriptions per year.

As the emphasis accelerated on cost containment, prescription drug program purchasers became less enamored with service and much more preoccupied with financial consequences. Casting perceived quality aside, the buyer moved toward what appeared to be a less expensive delivery system with limited risk - mail order. The apparent reasons for economy in the system were (1) economies of scale; (2) ability to substitute generic drugs in states with liberal substitution laws; and (3) a computerized information system for utilization review and claims processing. For these reasons, mail order programs were offered to union workers in the early 1980s.

The Problem

A major employer in East Tennessee adopted a mail order prescription program in 1984. It is projected that the adoption of this program removed prescription drug purchases in excess of $2,000,000 from the local market. Through conversations with employees utilizing the mail order program, pharmacists reported significant effects on dispensing, as well as unusual injuries.

Purpose

The purpose of the study was to determine the degree to which mail order program users differ from non-users regarding their satisfaction with prescription drug services.

Methods

A personal interview was designed for administration to adults residing at private residences in the county in which the employer is situated. The interview was pretested and modified to reduce and/or eliminate items which were easily misunderstood or confused the interviewee (Appendix A). Interviews were conducted by telephone by a trained interviewer. The interviewer was instructed about proper procedure, etiquette and telephone interview techniques. The interviewees were informed that this project was being conducted by the University of Tennessee College of Pharmacy, and that the project was examining prescription drug services and consumer preferences.

A sample of 300 residences was selected from the county telephone directory. The selection process utilized the systematic random sample technique. The interviewer called each residence and requested to speak to the husband, wife or head of household. Procedures to assure randomness and representation were used in the event that contact could not be made with the occupants. The interview process continued until 300 complete and usable interviews were obtained.

Results

Data from 300 interviews were coded, entered and tabulated by computer. These tabulated data were summarized to describe the characteristics of the sample, their preferences for prescription services and comparison of mail order user preferences to community pharmacy user preferences.

The tabulated responses are summarized as follows:

: 69 percent of the interviewees were women

: The number of occupants in each household were:

one - 17%
two - 46%
three - 14%
four - 15%

: 50 percent of the interviewees were eligible for some type of employer funded health care benefit. These responses were further identified as participating in the following types of prescription drug programs.

Deductible plan - 62%
Mail Order plan - 22%
Co-payment plan - 6%
Medicaid - 7%
Veterans plan - 1%
AARP - 1%

: Pharmacy use was reported as:

Community independent - 47%
Chain pharmacy - 42%
Mail order pharmacy - 11%

Mail Order Pharmacy Users

: Mail order pharmacy users were questioned further

- 34 interviewees (11 %) used mail order services

- Reasons for using mail order were:

First - Price
Second - Other: "because the Company
encourages me to use it"

- Number of prescriptions obtained each month by mail order:

one - 32%
two - 21%
three - 21%
four to five - 12%
six or more - 14%

- Services provided by mail order included:

	Yes	Consumer valued as important
medication record	- 41%	79%
prescription leaflets	- 47%	71%
insurance receipts	- 18%	21%
other (booklets)	- 21%	86%

- Mail order delivery time was typically:

7 days - 30%
8 days - 3%
10 days - 37%
13 days - 2%
14 days - 18%
15 or more - 6%

- Incidence of problems with mail order service:

		Yes
delays	-	12%
received wrong medication	-	0%
damaged containers	-	9%
lost in mail	-	0%
evidence of tampering	-	0%
other problems	-	3%

- Plans to continue using mail order

Yes - 100%

- Overall rating of mail order service:

excellent - 56%
good - 44%
fair - 0%
poor - 0%
100%

Community Pharmacy Users

: Community pharmacy users were questioned further:

- 266 interviewees (89%) used community pharmacy services

- Reasons for using local service were:

price - 33%
the pharmacist - 16%
other - 15% (including used for years 6%, dependability 4%)
services - 8%
location - 7%
convenience - 2%

- Number of prescriptions obtained each month:

none - 14%
one - 30%
two - 18%
three - 10%
four - 10%
five - 7%
six or more - 10%

- Services provided by community pharmacy:

		Yes	Consumer valued as important
medication record	-	74%	60%
counseling	-	59%	75%
insurance/billing	-	9%	10%
other (delivery, discounts, and OTC advice	-	19%	93%

- Incidence of problems with community pharmacy service:

		Yes
long wait	-	12%
wrong medication	-	5%
unfriendly employees	-	3%
other problems	-	1%

- Plans to continue using community pharmacy:

Yes - 99.6%

- Overall rating of community pharmacy services:

excellent	-	43%
good	-	53%
fair	-	4%
poor	-	0%
		100%

Conclusion

The incidence of mail order prescription service was only 11 percent in a community where the predominate employer has implemented the service. Most mail order users report few problems and the overall rating of the service was excellent or good. In fact, the rating for mail order services was slightly better than the rating for community pharmacy services.

PRESS ARTICLES ON MAIL-ORDER PHARMACY

Mail-Order Pharmacies' Sales Advance, Provoking an Outcry From Drugstores

YOUR
MONEY
MATTERS

By WALT BOGDANICH
Staff Reporter of THE WALL STREET JOURNAL

One prominent Georgia pharmacist calls it "madness." The Tennessee Board of Pharmacy says it threatens the "health, safety and welfare of all our citizens." And an editorial in the Patriot, a Harrisburg, Pa., newspaper, says it invites criminals and addicts to "terrorize the vulnerable elderly" by raiding mailboxes.

"It" is the rise of mail-order pharmacies. As the number of mail-order customers grows, so does a tide of criticism from community pharmacists and an occasional ally.

But are mail-order pharmacies really as dangerous as some pharmacists would like the public to believe?

"That's total nonsense," replies John R. McHugh, the president of the National Association of Mail Service Pharmacies. Adds James V. Manning, the executive vice president of Medco Containment Services Inc. of Elmwood Park, N.J., one of the biggest mail-order pharmacies: "There has never been any evidence supporting any claim by retail pharmacists that there are any public-health issues involved." As mail-order druggists tell it, the charges against them are merely a smear campaign arising from a mushrooming threat to drugstores' sales.

Certainly there is evidence that the mail-order pharmacies, which promise convenience and cost savings, are growing. One reason: They are winning endorsements from employee-benefit plans at General Motors Corp., United Technologies Corp. and some other big companies, which aim to cut drug outlays. Medco alone says it filled three million prescriptions in its fiscal year ended last June 30, a 30% jump from the previous year.

Market Share Grows

Mail-order drugs still make up only a tiny portion—about $100 million—of the $19.4 billion-a-year retail market for prescription drugs. (These industry figures exclude drugs dispensed free, partly through the mail, by the Veterans Administration.) But that share is growing. "I don't think it's anywhere near its peak," says Larry Lenahan, a benefits consultant with Buck Consultants Inc., New York, which finds that mail orders can be more convenient and less costly than buying from drugstores.

Says Larry Braden, the Georgia druggist who calls the trend "madness": "While mail-order programs were relatively dormant over the years, in the last six months we have seen a tremendous upsurge in this."

Late in 1984, Sears, Roebuck & Co. began offering mail-order drugs through Mature Outlook Inc., a membership club for the elderly. Another major retailer, J.C. Penney Co., already was in the business, through its Thrifty Drug Co. division.

At least one hospital has also jumped into the field. About six months ago, the not-for-profit Rush Presbyterian-St. Luke's Medical Center in Chicago began a mail-order drug program through a for-profit subsidiary, ArcVentures Inc. One ArcVentures customer will be Chicago itself; the city plans to buy mail-order drugs for 40,000 current and retired employees.

Nationally, the largest mail-order pharmacy, besides the Veterans Administration's, is run by the American Association of Retired Persons, a lobbying and service organization. This pharmacy fills more than six million prescriptions a year and employs 125 registered pharmacists. "They don't have to sell fertilizer or answer phones," a spokesman says. "We don't carry all that junk that other drugstores carry."

ONE DRUGGIST association claims that mail-order druggists can't guarantee the safe shipment of drugs.

Mail-order druggists acknowledge that mail orders aren't appropriate in emergencies, when drugs are needed immediately. To find customers, these druggists focus on users of "maintenance drugs"—those prescribed for such long-term ailments as heart disease and high blood pressure. That limits the market, but not much; maintenance drugs account for about 80% of spending on prescription drugs. Moreover, the ranks of the elderly, the biggest users of such drugs, are growing.

The mail-order druggists say they can provide drugs more cheaply than many stores do, because of low overhead, large-quantity purchasing and the use of generic drugs where possible. The druggists also say mail orders are ideal for people who have trouble getting to a drugstore.

Community druggists have taken to knocking their new competitors. Last summer the National Association of Retail Druggists began printing pamphlets that ask consumers: "When you buy prescription drugs by mail, do you really want to bargain away your health?" The association claims that mail-order druggists can't guarantee the safe shipment of drugs, visually monitor consumers' physical condition or personally answer your questions.

To prove its points, the association last fall set up a clearinghouse for collecting complaints against the mail-order druggists. While declining to disclose the names of the complaining parties, the association says that one consumer told of ordering a tranquilizer through the mail but receiving an anti-cancer drug instead.

In Fort Lauderdale, Fla., attorney Frank Amigo says he told the association about a mail-order customer who was sent the wrong dose of morphine—11 milligrams instead of 400. "It's really frightening," says Mr. Amigo. "This is a serious problem."

Further Charges

According to their critics, mail-order companies' errors are due largely to the companies' remoteness from customers. Mail-order druggists say they provide toll-free telephone numbers so that customers can speak with pharmacists, but the critics say these are no adequate substitute for face-to-face contact. The critics also question whether drugs might lose their potency if exposed to temperature extremes during shipment. And they say that shipping errors can result in consumers' lacking medication when they need it.

None of the critics' concerns amount to much, according to the mail-order companies, their customers and some investigators who have looked into the charges for regulatory agencies. Drugstores sometimes make errors, and "there aren't any more errors with mail-order pharmacies," says one investigator for a state pharmacy board. (He asks that his name be withheld for fear of alienating the community pharmacists who control the board.)

The mail-order druggists insist that they look after customers' health. At Medco, for example, computers "know exactly every quantity of drug going to everyone," says Mr. Manning. If a customer is taking several drugs that could interact poorly, he says, a company pharmacist will contact either the customer or the customer's doctor.

Medco also discounts claims that criminals will steal drugs from mailboxes. Medco says its packages aren't marked as containing drugs. Moreover, narcotics are sent by private carrier "so we can get a receipt," says Mr. Manning.

The mail-order companies also note that their critics, besides having a self-interest in the drug market, have shortcomings of their own. For example, according to New York City consumer-affairs officials, impoverished elderly people often live in neighborhoods where druggists don't even make deliveries. The officials also say New York drugstores posting "senior-citizen" discounts "may in many cases only be using the claim as a marketing tool, without truly offering the price advantages they claim."

THE WALL STREET JOURNAL
1/16/86

Mail-order drug system raises concern among pharmacists

By Marjorie Shaffer

Frederick Mayer, a pharmacist in Sausalito, Calif., tells of a man who came into his store with an empty bottle of Minipress. He desperately needed a refill, but had been without his heart medication for five days because the refill had not yet arrived in the mail.

When Mayer asked him why he used the mail to get his drugs, the man replied, "I get the drugs free through my HMO." Mayer asked him if he knew the cost of a stroke.

In Virginia, an 86-year-old man with a heart condition received through the mail the antiarthritic drug Feldene instead of Procardia. The man took the Feldene at the rate prescribed for Procardia—in doses four times higher than the maximum recommended for Feldene. He eventually developed a gastric ulcer and heart problems. He died of a heart attack.

The doctors treating the man said the Feldene overdose and the lack of Procardia did contribute to his death. The case was settled out of court for about $75,000, according to A. Davis Bugg Jr., a lawyer with the White Stone, Va., law firm of Dunton, Simmons & Dunton, which handled the case.

"Rightful concern"

Incidents like this, pharmacists allege, prove mail-order delivery of drugs is a public health hazard. "It's a rightful concern of pharmacy; if one case could happen, how may others are there?" asked Lou Sesti, director of the Michigan Pharmacists Association.

"I don't have a high opinion of it," said Charles West, executive vp of the National Association of Retail Druggists, which last year set up a clearinghouse for complaints about mail-order drug delivery.

"We get the routine kinds of complaints from people who don't receive medicine on time or in the proper condition, except we are not talking about widgets," said John Rector, NARD's general counsel. "When mail-order pharmacists are filling hundreds of prescriptions a day, there's going to be a lot of problems," he said.

But mail-order pharmacists maintain this is an exaggeration. "There are no facts supporting the contention that the error rate for mail order is higher than that at retail," said James Manning, executive vp at Medco Containment Services in Elmwood Park, N.J. the largest for-profit mail-order business in the country.

"We have quality controls, verified by several state Boards of Pharmacy, over the dispensing process that are substantially better than at retail. Our dispensing errors are negligible, far less than 1%," he said.

> "We get the routine kinds of complaints from people who don't receive medicine on time or in the proper condition, except we are not talking about widgets. When mail-order pharmacists are filling hundreds of prescriptions a day, there's going to be a lot of problems."
>
> —John Rector
> *general counsel,*
> *NARD*

Increasingly widespread

Despite the salvos fired off by each side, mail-order delivery of prescription drugs is becoming increasingly widespread as cost-cutting corporate America begins to find more ways to offer cheaper medical benefits.

Once mail-order drug delivery was restricted to nonfunded programs offered by the Veterans Administration, a 40-year-old program filling more than 20 million prescriptions a year, and the American Association of Retired Persons Pharmacy Service (AARP), which mails about seven million prescriptions a year. But in the last 10 years, mail-order for-profit businesses have spung up. They began offering the service to corporations, which offer the program as an alternative to major medical programs, and business boomed.

Today, Medco's mail-order arm, National Pharmacies, mails more than three million prescriptions a year. Among its clients are such heavy hitters as General Motors, United Technologies, Occidental Petroleum, ALCOA and Grumman.

There are at least 10 other for-profit mail-order drug delivery businesses operating.

In 1984, Sears began offering its customers the service through its Mature Outlook program. And J. C. Penney has been offering the service for several years through its Thrift Drug subsidiary.

Another major drug store chain, Walgreens, expanded its mail-order service earlier this year when it announced it would provide the service to more than 100,000 customers through a contract with Mutual of Omaha.

And at least one hospital offers the service. Last year, ArcVentures, a subsidiary of Rush Presbyterian-St. Luke's Medical Center of Chicago, began offering a program.

Some municipalities and state governments, including New York State, also are beginning to offer the service to their employees. And at least one pharmaceutical company, Baxter Travenol, based in Deerfield, Ill., has begun a mail-order prescription drug service in the Midwest.

Appeals to employees

Employers have been drawn to mail-order drug delivery services because it saves money on maintenance medications used to treat chronic illnesses, like diabetes and high blood pressure. Mail order cannot be used for emergency treatments. Money is saved through large-volume purchasing discounts, fewer dispensing fees because customers are supplied with up to a 90-day supply of medications, and fewer claims processing fees. Large savings are also realized through a much higher rate of generic substitution for mail-order drugs, ranging from 10% to 35%, compared to retail pharmacy.

"Overall, consumers can usually save 50% or more on mail-order purchase on either brand or generic products," writes David Saks, a drug expert with Morgan, Olmstead, Kennedy & Gardner of New York City, in a research report.

> "There are no facts supporting the contention that the error rate for mail order is higher than that at retail."
>
> —James Manning
> *exec vp,*
> *Medco Containment Services*

But does mail order really save corporations money? Says Lou Sesti of the Michigan Pharmacists Association, who has been privy to some of the negotiations for Ford Motor Co.'s and Kellogg's mail-order programs, "Management doesn't save much money, but it's a pro-labor bargaining chip for the unions."

Interviews with two benefits managers at corporations that have mail-order service programs with National Pharmacies underscore this point. At Mountain Bell in Colorado, which has had the program for over a year, Paul Tracey, staff manager for benefits, said, "We should have seen a savings,

Does mail-order pharmacy pose a competitive threat to conventional drug stores, or is the issue one of service? Observers are divided on the question.

Feedback on mail order

Excerpts of complaints received by NARD about mail-order delivery of prescription drugs.

From Davison, Mich., a worker in a Baptist Church:

"Received generic phenobarbital 60mg made by Lilly on several occasions, but the last precription filled was twice as large a tablet and had different markings. Had to take the Rx to my local pharmacy and ask my pharmacist for assistance. He tried to call my mail-order pharmacy to ask if the prescription was correct, as he did not recognize the pills, and was told they do not take collect calls under any circumstance, so finally he found out that my pills were correct by calling a local hospital's drug information center, but I am very unhappy with the service of mail-order-pharmacy. Especially annoying is switching generics and giving no notice of the change, or telling the manufacturer on the label."

From Little Rock, Ark., a retiree of Union Life Insurance Company:

"In February 1985, I ordered a prescription refill of #F342875, hydrochlorothiazide 25mg, from Retired Persons Pharmacy of Texas. The tablets I received from them did not look like the ones I had been taking, so I took them to my druggist for identification. He told me they were not hydrochlorothiazide, so I did not take them."

From a spouse of a Uniroyal worker in Missouri:

"My insurance company insisted that I use generic drugs, and it seemed that every time I got my medicine, it was a different color. I had to wait till I called to make sure it was O.K. or return it. . . . "

From Sweetwater, Tenn., a director of pharmacy in a small hospital:

". . . Recently, a patient brought in his medications . . . and he had in his possession thousands of each of his antihypertensive medications . . . filled up one-half of a grocery bag . . . All I know in this instance is that an elderly man living in Tennessee obtained through mail-order prescription from New Jersey multiple thousands of tablets. This most definitely is a health hazard to dispense in such large quantities. . . ."

but it is costing us more than our previous insurance program; the company still has to pay for the prescriptions." However, he added, "The satisfaction of the employees more than offsets the cost of the program."

At Grumman Corp., an aerospace giant in Bethpage, N.Y., benefits manager Mary Cronin said, "We're happy if we break even" on the new program for retirees with National Pharmacies. "It's very difficult to give additional benefits, so you try and be creative and come up with programs that don't cost the company a lot, but give employees something. Grumman is a very paternalistic company," said Cronin.

Despite the salvos fired off by each side, mail-order delivery of prescription drugs is becoming increasingly widespread as cost-cutting corporate America begins to find more ways to offer cheaper medical benefits.

Found little savings

Cronin also said that after a fairly thorough comparison of drug prices in local pharmacies, including chains, with National Pharmacies' prices, she concluded that there really was not much savings. "They were all very close on prices, especially the chains. It was really hard to find a difference," she observed.

Apparently, at least for some corporations, it is only the employees who do save money on mail-order programs, some of which require no co-pay for prescription drugs.

Mail-order prescription drug services employ hundreds of pharmacists who fill prescriptions in an assembly line-like operation.

Central to mail-order delivery of prescription drugs, say pharmacists, is the lack of face-to-face contact between pharmacist and patient, and the severing of the traditional doctor-pharmacist-patient relationship.

But pharmacists contend that money is no substitute for health. "It's cost containment at any cost, no matter what you sacrifice," said John Rector of NARD.

Central to the mail-order delivery of prescription drugs, say pharmacists, is the lack of face-to-face contact between pharmacist and patient, and the severing of the traditional doctor-pharmacist-patient relationship.

"It all adds up to a complete, absolute confrontation with pharmacy as a personal service," said Sesti, of the Michigan Pharmacists Association.

Pharmacist input

Without a local pharmacist, druggists contend, there can be little follow-up and knowledge of a patient's medical history. Thus, there is plenty of room left for error by supplying drugs that can adversely interact. But mail-order pharmacists say they keep meticulous records on all their patients. "We may not see every one of our patients every day or on a one-to-one basis, and I don't know any pharmacy that does," said Delbert Konnor, director of professional services for AARP, at the American Pharmaceutical Association earlier this year.

But, Konnor said, each patient is "in on our patient profile system: each is a special charge account patient with full credit; each has the right to telephone us and discuss medication with a pharmacist practitioner; and each of our patients can write to us explaining medication needs."

Most mail-order services also provide a drug information leaflet on prescription drugs and information that alerts patients to drug interaction problems. And, said Medco's Jim Manning, specially insulated packages are used to mail drugs to ensure that temperature extremes do not damage the goods. "Most drug stores get their drugs through UPS, and is that a problem?" he asked.

Manning maintains that pharmacists are enraged about mail-order delivery of prescription drugs because it is another competitor in an increasingly difficult business. It is not a service issue, he maintains.

Overall, mail-order prescriptions only account for about 2% of the $25 billion U.S. prescription drug industry. "That certainly doesn't seem like a competitive threat—does it?" said Konnor. But what happens when 2% rises to 7%, pharmacists retort.

A sampler of organizations offering mail-order pharmacy services

Organization	*Estimated Rxs filled per week*	*Dispensing locations*	*Major customers*
Veterans Administration	385,000	172 medical centers 220 outpatient clinics	U.S. veterans
American Association of Retired Persons	135,000	Calif., Conn., Ill., Pa., Ore., Mo., Ind., Tex., Wash.	22 million AARP members
Medco Containment Services	100,000	N.J., Ohio, Calif., N.Y., Nev.	General Motors, United Technologies, Occidental Petroleum, ALCOA, Grumman
Health Care Services	25,000	Pa.	Ford Motor, Goodyear
Express Pharmacy Services (Thrift Drug/ J.C. Penney)	18,000	Pa.	General Motors, Pitney Bowes, Rockwell

By concentrating on the public health issue, associations like NARD are trying to focus attention on the hazards of mail-order delivery, rather than its competition with retail pharmacy. Perhaps a harbinger of this approach is the call by Rep. John Dingell (D-Mich.), chairman of the House Subcommittee on Oversight and Investigations, to "closely examine the mail-order dispensing of pharmaceuticals to determine whether or not the public health risk of this growing practice is reasonable." However, a member of Dingell's committee said that such an investigation will not take place for some time.

Efforts to restrict

Meanwhile, there has been no study to determine whether mail-order pharmacy is a public health threat. In the absence of federal intervention, several state boards of pharmacy have tried to support legislation that would restrict mail-order delivery of drugs into the state. The state pharmacy boards have been particularly rankled because they have little, if any, control over the licensing procedure of these out-of-state businesses.

One thorny issue is substituting generics for brand name drugs. Most mail-order businesses are deliberately located in states with fairly liberal substitution laws. But many states, such as Florida, Arkansas and Mississippi, have strict controls on substitution.

Both Florida and Mississippi failed this year to pass legislation that would have required out-of-state mail-order pharmacies to be licensed by the state and adhere to the same regulations as in-state pharmacies. In Mississippi, the governor vetoed the bill, citing interference with interstate commerce as unconstitutional.

"Want a fair shake"

"We are not saying do away with mail order, but we do want a fair shake with these people," said Jim Powers, executive director of the Florida Pharmacy Association. "How are we going to make sure that people in other states are complying with our laws?" he asked.

"I think it is a great challenge that pharmacists can meet by providing better services."

—Lou Sesti
director,
Michigan Pharmacists Association

So far, only Arkansas has passed an act that would actually regulate out-of-state mail-order pharmacies. But the regulations must be formulated and reviewed by several committees before it can become law—a formidable challenge.

Last month, Assemblyman William J. Filante, a physician from California, called for state legislation that would establish certain in-state controls of mail-order pharmacy. A spokesman for Filante said he will try to stay away from the interstate commerce issue.

Pharmacist's challenge

But until federal or state legislation can more fully regulate what pharmacists see as a threat to the public health, mail order will continue to grow. And it is ultimately up to the pharmacist to meet this challenge.

As Lou Sesti said, "I think it is a great challenge that pharmacists can meet by providing better service."

Feds Go Mail Order

OPINION

by Gil Finkelstein

It is no surprise to me that government administrators once again showed their insensitivity to public needs and welfare in order to cut the costs of the health benefit program for federal employees.

Beginning in January 1987, federal employees and retired personnel who are enrolled in the Federal Blue Cross and Blue Shield Service Benefit Plan, are eligible for mail order prescription service. Under this coverage, the patient may choose to deal with his local pharmacy and the plan will reimburse 80% of the expense after the individual has met a $200 deductible, or he may use mail order and receive up to three months of medication for $3.00. This is one option.

The second option is a $250 deductible and 75% reimbursement if he uses a local pharmacy, or $5.00 for mail order. Is this freedom of choice or coercion.

I, for one, am not going to take this economic abuse sitting down. The NARD, in its November 15, 1986 newsletter stated that "It's sadly ironic that federal lawmakers require medicaid beneficiaries be given freedom of choice, and that has been largely taken away for federal employees and retirees. Patients deserve to have all the facts on mail order dispensing before they opt to an option they may find unacceptable later."

NARD has available a consumer brochure entitled "Mail Order Prescriptionis are No Bargain and can be obtained for a modest cost from NARD in Alexandria, Virginia.

I am informing my patients that my services cannot be duplicated by mail order and that they cannot expect me to answer their questions arising from prescription medication obtained for sources other than my pharmacy. They can also be vocal to their legislative representatives regarding their 2nd class health benefits.

In the descriptive literature that the federal employee received regarding the mail order program, I noted a section under the title "Why is the mail order prescription program important to me," the word "Service" in bold letters. Under this service heading it states that a patient can call a toll free number and talk to a "Mail Order Prescription Service Representative" regarding questions about their prescriptions.

Don't you just love it! They call their pharmacists "Customer Service Representatives" or just maybe they are not pharmacists. I guess they have to cut costs somewhere.

Let's get out front and tell the public who we are and what we do and that Pharmacy can't be "licked". That's a pun. (stamps — mail order)

Drugs by mail

The Patriot, Harrisburg, PA
Wednesday, April 17, 1985

Abuse potential outweighs convenience

THERE ARE a number of reasons why sending prescription drugs by mail to elderly patients in Pennsylvania is a bad idea. The growing threat of drug abuse, the increase in crimes against the elderly and the danger of unsupervised "over-medication" are three that readily come to mind.

The House Finance Committee last month unanimously approved a measure to allow pharmacies to dispense drugs through the mail to hundreds of thousands of senior citizens under the state's Pharmaceutical Assistance Contract for the Elderly (PACE) program.

The bill, since tabled for further study by the House Consumer Affairs Committee, is expected to be brought back up for discussion next week.

This legislation has the support of senior citizens groups, who claim it facilitates service to the housebound elderly. Pharmaceutical interests generally oppose this and other mail-service proposals as unethical and poor medical practice.

We agree. Mail-order drugs for the elderly — or anyone else, for that matter — is an open invitation to abuse.

It invites all manner of confusion growing out of the separation of the patient from the provider. It invites over-dependence on drugs by elderly patients. It invites bureaucratic and logistical errors which would be merely irritating if they did not involve people's health and safety. But perhaps most seriously, it invites criminals and addicts to raid mailboxes and terrorize the vulnerable elderly in their quest for drugs.

The American Association of Retired Persons (AARP), which has promoted the dispensing of prescription drugs through the mail, sees the plan as a convenience to the 315,000 PACE subscribers in the state. If it is a convenience, it is only a superficial one. True, drug store home delivery seems to have gone the way of the nickle soda, but with all the state-funded apparatus currently dedicated to serving the needs of the elderly, this is hardly an insurmountable problem.

Rather than facilitate mail-order prescription service and all the problems that go along with it, we feel the state should be looking at ways to help the elderly better understand both the benefits and the limitations of prescription drugs. Though we should not put life-saving medicines out of their reach, neither should we thrust upon them unnecessary and repetitious medication for no other reason than it is a government-subsidized bargain.

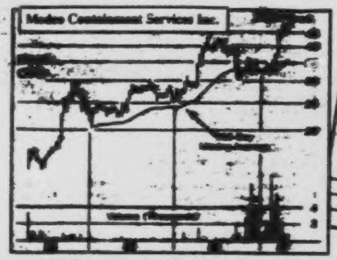
House conferees have expressed doubts about the security aspects of the legislation, and rightfully so. But our objections are even more basic. Medication is best when prescribed and administered with the usual professional supervision. With mail-order prescriptions, the roles of doctor and pharmacist become secondary to the day's mail delivery. Certainly that cannot be of benefit to the patient.

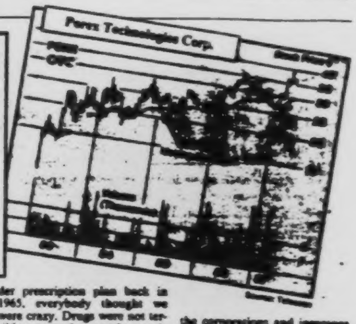
The last thing the elderly of Pennsylvania need is another bureaucratic device encouraging them to take drugs.

Rx for Hot Stocks

Why Porex and Medco Sell at Eye-Popping P/Es

By KATHRYN M. WELLING





NEITHER Medco Containment Services nor Porex Technologies, its parent, claims a potential AIDs cure or the first superconductor-powered computer. Not even plans for a spy-proof embassy. Yet, at current prices, the market is valuing the two New Jersey-based companies, which together reported just over $150 million in sales in their latest fiscal year, at a cool $1.2 billion.

Quoted at 36, Porex, with fiscal '86 net of $9.2 million, or 81 cents a share, is changing hands at a whopping 43 times earnings, while Medco, at 46½, is trading at an astronomical 100 times the $7.1 million, or 46 cents a share, it posted in its latest fiscal year.

Clearly, investors are excited about the companies. The companies' businesses, as intimated, are not on the leading edge of technology. But obviously, running mail-order pharmacies and servicing third-party payers can set speculative blood racing just as surely as the latest biotech breakthrough. For Medco and Porex, their fans insist, are riding such powerful social and political tides as medical cost containment and the graying of the population.

Porex's corporate name is derived from a tiny Georgia subsidiary that makes and distributes porous plastics, but its sizzle in the Street it owes to Medco Containment Services. Based in Elmwood Park, N.J., the 54.5%-owned Porex unit runs the largest for-profit mail-order pharmacy operation in the U.S. Medco, through another subsidiary, also provides a prescription drug claims processing service that permits insured persons to pick up an Rx at a network of 48,000 drug stores nationwide, simply by presenting a plastic card and making a small co-payment. Through its integration of these services, Porex says, it has created "what it believes to be the industry's most comprehensive prescription drug cost containment and reporting programs."

However, to what extent and under what conditions Medco's—or any mail order pharmacy's—services keep a lid on costs for insurers are matters of considerable dispute. At the same time, new competitors are entering the business in growing numbers and they now include units of major drug chains as well as insurance companies and such diversified giants as Sears.

Financially, Porex and Medco are distinguished by possessing very little actual cash but sizable caches of junk securities. Their guiding light is Chairman Martin Wygod, a dealmaker who first achieved prominence on Wall Street as a young 'Sixties gunslinger. In recent years, Wygod has been a fairly active participant in numerous Drexel Burnham Lambert junk securities deals, and the products of junk offerings are liberally represented in Porex's and Medco's investment accounts.

Medco's services, according to documents the company and its parent have filed with the Securities and Exchange Commission, are designed to slash the cost to corporations, labor unions, insurers and the like of providing prescription drug benefits to plan members. Its claims processing unit, Paid Prescriptions Inc., purports to save "the average plan sponsor approximately 15%-20% of the total cost of providing a prescription drug benefit" by controlling the pricing of medicines distributed by drug stores in its network. It also boasts a "sophisticated claims reporting capability" to help sponsors track the cost and utilization of their insurance plans.

For its part, Medco's mail-order pharmacy claims to fill Rxs for so-called "maintenance" drugs (ones used to treat chronic illnesses—diabetes, say, or arthritis) at a cost "lower than can generally be provided either by retail pharmacies or by Paid." Some 15%-20% lower, according to Medco's analytical boosters in Wall Street.

The concept of selling medicine through the mail is far from new. Sears, Roebuck and Montgomery Ward, among others, were doing it before the turn of the century. The Veterans Administration started a mail-order pharmaceutical service for former servicemen in 1946. And the American Association of Retired Persons' mail-order Rx plan, which last year filled some eight million prescriptions, making it the largest non-government (or non-VA) program, dates back to 1959. That was the year Sen. Estes Kefauver held widely publicized hearings on drug safety, which at least some in the pharmaceutical industry credit with spawning a number of small mail-order Rx operations around the country. But the idea didn't exactly grow like wildfire and the business, until relatively recently, remained largely a collection of mom-and-pop operations.

Indeed, reports an International Ladies Garment Workers Union official, "When our forefathers started up our mail-order prescription plan back in 1965, everybody thought we were crazy. Drugs were not terribly expensive, and people liked using the corner pharmacy."

But prescriptions are no longer an insignificant item in many budgets, particularly retirees', in part, because drug cost increases have lately far outstripped the rise in the consumer price index. And that has tended to focus the attention not just of individuals, but of the corporations and insurance companies that pay many of their medical bills, on controlling Rx outlays. Hence the niche for Porex and Medco and the rich evaluations of their shares.

Porex can trace its roots back to 1961, but its connection with drug sales through the mail dates only to 1983. That's when

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Porex formed Medco to acquire the mail-order vitamin and prescription businesses of Victor Posner's APL Corp. Porex paid $3 million in cash and 2.45 million of its shares, which were then trading around 21. The transaction would have left Posner controlling some 40% of Porex's shares except that, as Up and Down Wall Street reported in 1984, he immediately sold half his stake in the company to Drexel Burnham Lambert, at 15¼, a sizable discount to the market price.

Porex Chairman Wygod has subsequently reshaped Medco, selling off its vitamin operations and, in a complex series of transactions in 1985 and 1986 that involved Drexel, acquiring Rx processor Paid Prescriptions. The price paid for Paid, essentially, was $14.7 million in cash, only $8.4 million of which Porex put up, and roughly $13 million in Porex shares—559,000 shares, to be precise, trading, at the time of the transaction, at 23¼ each.

According to documents the companies have filed with the SEC, Medco couldn't directly acquire Paid in January 1985, because the number of shares that it would have had to put up, together with $14.7 million in cash, "would have represented a substantial portion of the Company's [Medco's] net worth." But during that month, Medco's shares were quoted in a range of 20¼-23¼, more or less at parity with Porex's, and its balance sheet showed more than $50 million in book value.

However, of Medco's book value of $57 million fiscal '85 year-end, nearly half, or $26.2 million, represented good will. The balance sheet also listed $11.2 million in marketable equity securities and other investments on that date, but that consisted mostly of $3 million in high-yield preferred issued by First Executive Corp. and SFN Cos., and over $8 million in junk bonds issued by Calton Inc., MacGregor and Unifi Inc.

Medco's interest in junk securities doubtless relates to its ties with Drexel Burnham. Drexel, as noted, helped Porex swing the October 1983 purchase of APL's mail-order pharmacy business. And that same month, Rosam II Associates, a partnership formed by some Drexel employees, bought 827,195, or 7.5%, of Medco's shares at $2.90 each, on average, and $2.5 million principal amount of a subordinated note from the company. Five months later, Drexel and Thompson McKinnon Securities sold 1.4 million Medco shares to the public at $14. Drexel partnerships including its employees and Executive Life, a prominent Drexel client, subsequently were involved in the complicated transactions in which Porex bought Paid Prescriptions in January 1985 and, 15 months later, sold the company to its Medco subsidiary for stock.

Last October, Drexel and Executive Life also figured prominently in the list of institutional investors who traded in $99 million principal amount of Porex exchangeable subordinated notes (which Drexel had privately placed in late '84) for 3.96 million fully registered Medco shares. Drexel got 1.558 million of the shares and the insurer, 600,000. The swap cut Porex's equity stake in Medco to 54.5% from over 75%, and resulted in a $26.5 million net gain for Porex in its second fiscal quarter ended December.

According to Porex and Medco, their mail-order pharmacy service saves the corporations and institutions that foot the bills substantial dollars because:

1. Its professional pharmacists are employed only to dispense drugs, and hence are more efficient than retail druggists who spend a good amount of time selling toothpaste. And its six high-volume, mechanized and electronically controlled pharmacies are faster and more accurate in filling Rxs.

2. Its computerized dispensing controls sharply reduce the likelihood that prescriptions will be filled for ineligible people, minimizing such costs to clients. At the same time, Medco takes over claims processing, which relieves insurers of that overhead.

3. It takes advantage of volume purchasing to obtain drugs at lower cost than traditional neighborhood pharmacies and some retail drug chains.

4. Its transaction costs are lower because participants can typically receive up to a 90-day supply of a maintenance drug, rather than the 30-day supply commonly dispensed at retail, and thereby avoid a couple of dispensing fees and the cost of filing a couple of claims.

5. It strictly enforces a policy of substituting lower-cost generic drugs for branded ones whenever possible.

In addition, Porex and Medco claim, individuals utilizing their mail-order pharmacies benefit from the convenience of having their Rxs delivered to their door, and generally also from lower out-of-pocket copayments for their drugs.

Predictably, the National Association of Retail Druggists disputes most of these claims. But even disinterested parties might question what some of these "advantages" are really worth to Medco's clients—or how much Medco can afford to make them worth. Even the company's claim that its assembly line pharmacies are inher-

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ently more efficient than the corner druggist and thus will produce prescription cost savings is open to question. For it depends on the assumption that they are running at something approaching optimal capacity, while independent druggists are inevitably slothful.

Then too, Medco's boast that it can produce savings via volume purchasing, while undoubtedly true, is hardly proprietary. Many of the nation's retail drug chains buy significantly more pharmaceuticals than it does. And, for that matter, the vast majority of independent druggists can participate in volume purchasing through buying groups.

While there's no doubt, moreover, that Medco can order its pharmacists to substitute generic drugs for more expensive branded ones, whenever legally possible, the company is bound by the same rules that apply to all druggists when it comes to dispensing generics. And any pharmacist, provided the proper incentives, can do the same thing. Thus, while Medco may fill Rxs with generics more often than, as Medco's financial documents put it, the "average retail pharmacy," the company is hardly the only druggist to do so and its programs aren't the only way a benefits provider can encourage generic substitution.

The most serious controversies over mail-order drug programs in the pharmaceutical and benefits worlds, however, stem from claims that programs like Medco's save transaction costs and, more broadly, that by integrating a mail-order plan with a retail-card system and claims reporting system, as Medco does, even greater efficiencies can be achieved.

Last fall, PCS, a Nasdaq-listed, 80%-plus-owned subsidiary of McKesson, the huge drug distributor, fired the first volley in what threatens to become a war of actuarial reports on mail-order drugs. PCS's main subsidiary, Pharmaceutical Data Services, is the leading provider of prescription drug claims processing services to health plan sponsors—the IBM to Medco's Paid unit's Apple, in other words.

PCS is prevented by its agreements with McKesson from getting into retail drug sales, including mail order. But about 25% of the 14 million people covered by plans it administers are eligible to use mail-order programs. And two years ago, in its role as "objective adviser" to benefits plans sponsors, according to PCS President Donald B. Dahlin, his company asked an outside actuary to study mail-order plans to find out how much money was being saved and where the savings were coming from. The actuary came back last summer, Dahlin reports, and said that in the plans he'd looked at, "sponsors were actually spending more money by using mail order than if they hadn't offered that option."

PCS, recalls Dahlin, knew it has a controversial report on its hands. The study seemed to fly in the face of all the perceived cost-savings advantages of mail order. And, he insists, "We're not anti-mail order, we're not anti-chain, we're not anti-independent. We're trying to represent the best interests of our plan sponsor clients. It's that simple." So PCS—what else?—ordered a study of the study. The second one generally supported the approach, results and conclusions of the first, but advised that care should be taken in interpreting its results since it covered only one year of experience with mail-order plans. And it, of course, recommended further studies, which are under way.

PCS announced the results of the first study last September. It found, specifically, that although mail-order Rxs, overall, had 4% lower unit costs than community pharmacies, they had 9% higher utilization. The net result for the benefits sponsor was 5% higher costs in plans that doled out 180 days' worth of medicine at a time and 2.7% higher costs in 90-day programs.

The reason for the higher utilization rates, the study said, was a phenomenon known in the trade as "wastage," the percentage of prescriptions filled, but not used. It occurs when a doctor orders a medication change before an entire Rx is consumed, when the pills are lost, or an individual simply stops taking the medicine. The study also found that wastage is most pronounced among older people, due to heavy prescription switching, particularly when taking antiarthritics. This makes old folks poor candidates for getting three to six months' worth of medicine at a time, at least if a plan sponsor is concerned about holding down costs.

While waiting for Towers, Perrin, Forster & Crosby and several other actuarial firms to complete subsequent studies, PCS also engaged the Gallup Organization to poll consumers on the contents of their medicine cabinets. The Gallup interviewers, Dahlin says, asked people to physically check their pill bottles and count the number of capsules or whatever they had on hand and asked how many were left over from old Rxs. The pollsters found, Dahlin re-

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parts, that there were slightly more than twice as many unused drugs in the homes of people who used mail order as those who didn't.

None of these results have completely turned PCS off on mail-order drug programs, however. The studies simply indicate, Dahlin says, that to save plan sponsors' money, they'll have to be structured more carefully than they are now. He suggests that future plans should perhaps limit the dispensing of 90-and-more days' supplies—at least on the first couple of prescription fills—to classes of drugs where the amount of Rx-switching and the resulting wastage is relatively low.

For its part, Medco hasn't exactly taken the PCS studies lying down. Just a few weeks before PCS's initial public offering was scheduled last November, Medco fired off a letter to PCS, challenging the results of its actuarial studies as they apply to its operations and threatening legal action. That earned Medco, which wasn't identified by name, a paragraph in PCS's prospectus, but no suits have been filed. Instead, some weeks later, Medco sent a several-page letter to many of the nation's corporate benefits managers, finding fault with PCS's studies. Medco reportedly has its own actuarial consultants at work on studies for it.

An amendment Medco filed in late October to its form 10K annual report to the SEC has this to say on the controversy: "The company is aware that PCS has recently published information which criticizes the cost effectiveness of mail service pharmacies. The company does not believe that the information accurately applies to the mail service programs and integrated prescription drug programs offered by the company."

At least one of Medco's major clients, however, by the very design of its mail-order drug benefits, lends credence to the PCS study's results. That client is the International Ladies Garment Workers Union, Medco's first big customer, which accounted for 25.7% of the company's sales in the nine months ended June 1984, 15.4% in fiscal '85 and 9.2% last fiscal year. The ILGWU, as noted, was a pioneer in mail-order Rx plans and a customer of Medco's predecessor companies for many years.

The union plan, an official says, permits members to buy only a 30-day supply of maintenance drugs at a time, because "there's a lot of wastage" in programs that permit 90-day-and-up refills. What's more, the IGLWU plan administrator says, the union offers only a mail-order plan, and not mail order combined with a retail-card plan (although Medco offers those in conjunction with its Paid subsidiary), because such combined plans foster more utilization than the union's hardpressed members could afford to pay for.

Whatever the actuaries eventually decide—if they agree at all—the controversy about the cost-effectiveness of mail-order drugs takes some wind out of Medco's fans' sails, if for no other reason than what it implies about the growth potential of mail-order drugs. Hard figures are hard to come by. But most industry, as opposed to Wall Street, observers estimate that drugs for chronic illnesses account for something less than 50% of prescriptions written and slightly more than half of the dollar volume of Rx sales.

All these maintenance prescriptions are not prime candidates for mail-order sales, however. As PCS's Dahlin asks, "Is that the potential market for mail order? Or, is the potential market only those drugs that people consistently use for longer than X period of time, per refill? I think that's really the answer. We don't know what that number is yet. But it's certainly lower than the total number or percent of maintenance prescriptions written."

In like vein, the potential market for mail-order pharmaceutical services geared to people covered by major medical insurance (as Medco's are) isn't, as some enthusiastic Wall Street reports have suggested, the 170 million-plus folks so covered.

In the first place, the mail-order pharmacies are directing their pitches mostly to employers who sponsor health plans, and not to individuals who purchase their own major medical coverage. That brings the number of folks covered by major medical down to 145 million. And secondly, according to Dahlin, most of the interest in mail-order plans is coming from large, self-insured corporations with health plans that can relatively easily be changed to include—and promote—the services. But these plans probably cover something less than half of the folks in this country with employer-sponsored major medical. And there's much less interest on the part of the insurance companies that cover people employed by medium- and small-sized businesses. That's because, asserts Dahlin, the administrative costs involved in implementing and promoting mail-order plans overshadow, at least for now, any unit cost savings they might produce.

To be sure, even 60 million or 70 million potential users is a good-size market, particularly if, like Medco, a company is currently covering just 11.5 million or so people—some five million of whom just became

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Medco clients at Jan. 1. And there's considerable potential for the company to grow, even if it were to stop adding new corporate clients. Assuming, that is, that it could increase the utilization of its services by people covered, which reportedly runs to something like 20%.

But here, too, there are doubts that Medco's interests really match those of its clients, the health-care plan providers. One of Medco's new clients, for instance, NCR Corp., may prove more typical than the mail-order pharmacy operator would like in its sensitivity to the utilization issue. Douglas M. Bartlett, the executive in charge of the computer company's employee benefits, is quite straightforward about why NCR started offering its workers a mail-order pharmacy option in January. The rapidity of the increase in the company's overall health-care expenses in 1986, when many of its other costs rose only modestly, coupled with a sharp jump in the utilization of its existing Rx benefits.

But he's just as straightforward about an issue that concerned NCR greatly as it designed its new plan: Since somewhere between 25% and 50% of all prescriptions are never filled, NCR wanted to guard against the increased convenience and discount prices of a mail-order plan increasing its costs by encouraging utilization. Any number of studies, Bartlett says, show that is precisely what happens with "blended plans" that combine a retail drug store prescription card (like Paid's) with a mail-order system (like Medco's). Thus NCR, he says, was careful to design its mail-order plan to provide for centralized control of dispensing, so that it can get a continuous reading on how usage under the new plan compares with its traditional one, which employees remain free to use. In other words, NCR is trying something new, but it's alert to the possibility that the promised savings won't materialize.

On another score, while Medco is going all out these days to sign up as many new corporate clients as possible for its mail-order drug business—and enjoying some considerable success, as noted—it's hardly alone. What once was the sleepy industry described earlier has, in the last three or four years, come alive with new or revived participants.

Leaving aside the nonprofit American Association of Retired Persons and the VA, the for-profit roster now includes Health Care Services, Express Pharmacy Services, Thrift Drug, a J.C. Penney unit, Walgreen, America's Pharmacy, a unit of Caremark Inc., Medi-Rx America Inc., Baxter Travenol, Revco, Sears and a spinoff from Chicago's giant Rush-Presbyterian St. Luke's Hospital, among others.

In other words, the mail-order pharmacy business isn't starting to draw a crowd, it already has one. And, since barriers to entry are practically nil (all that's needed is a plant and claims processing capability and there's even an industry association that can provide a blueprint for that), it's likely to get more crowded still. At least until the inevitable shakeout. Most mail-order druggists and their fans, predictably enough, insist they'll be able to grow at 100% per annum for the foreseeable future, but already signs of trouble can be spotted.

Pricing is one. Says an America's Pharmacy spokesman, "I don't think the business can get much more competitive. People are basically giving the drugs away to build volume in a low-margin, high-volume business." And Medco itself gives a backhanded acknowledgment to the business's increased price sensitivity when it claims that the PCS actuarial studies don't apply to it because its current tabs are so much lower than the ones in effect during the study.

But pricing isn't the only measure of the industry's intensifying competition. Company managers were all abuzz recently, though nobody was willing to go on the record, about the "dirty pool" involved in one company's "stealing" a particularly lucrative government contract from a firm that had helped set it up in business.

What's more, plan sponsors, who just a few years ago had trouble finding several mail-order providers to bid on their business, these days report no shortage of eager applicants. That almost inevitably will lead, benefits consultants agree, to commodity pricing of mail-order drug services, which is just what the plan providers like to see.

But Medco, at least, doesn't boast the kind of lush margins that allow for a lot of downside. Its pre-tax margins generally have run around 9½-9.5%, which—superficially, at least—isn't too shabby. But a closer inspection reveals that, if one subtracts the considerable interest income Medco has been reporting on its cache of junk securities, its pre-tax margins from operations drop to about half that 9.5% rate.

To be sure, Medco, and its parent, Porex, disclose right up front in their 10K reports that they are in another business besides medical cost containment. It's dubbed their "acquisition program." And the documents make no bones about the fact that Chairman Wygod has virtual carte blanche to raise and spend cash, shares and debt on acquisitions without shareholder approval. So perhaps it can be argued that interest on Wygod's war chest is operating income, although whether those earnings should be accorded a stratospheric multiple is another question.

There's no question, of course, that with Porex and Medco currently trading, as noted, at 43 and 100 times earnings, respectively, investors aren't paying any mind to such niggling concerns. But the suspicion won't die, either, that the identity of Medco's major holders, and their close ties to Drexel, have more than a little to do with such shareholder sang-froid.

Medco's most recent filings with the the SEC indicate that Porex controls 54.5% of its stock, Executive Life Insurance Co., 10.3% and Drexel Burnham Lambert, 9.6%. That adds up to almost 75% of Medco's equity in pretty friendly hands, without even attempting to add in the shares owned by officers and directors or various Drexel employees and clients. Just to complete the circle, it should also be noted that the two largest shareholders in Porex, according to its Febarary 1986 proxy, are First Executive and Victor Posner's APL Corp., each with just over 11% of its equity. And just this past January, Porex bought 2.3 million of First Executive from the insurer in a private placement.

After all, what are friends for? ■

FORBES July 27, 1987

Medi-Rx America, Inc. is in the mail-order drug business. Rule one for investors and customers: Know your management.

What's not in the prospectus

By Gretchen Morgenson

GETTING PRESCRIPTION DRUGS by mail is an idea whose time has come. It's convenient, especially to America's aging population. It's cheap: Prescriptions by mail are 5% to 40% off prices at the corner pharmacy. Drugs-by-mail sales have grown 50% each year since 1981, to $750 million today. Analysts at Arthur D. Little estimate that sales will reach $2.8 billion in 1991—nearly quadrupling in just five years.

Who gets the rewards? There are a handful of players in the mail-order prescription drug business. Medco Containment Services, Inc., based in Elmwood Park, N.J., is the largest: $140 million in revenues last year. J.C. Penney is also in the business, with its Thrift Drug subsidiary. Baxter Travenol is another player.

A small but growing competitor is Medi-Rx America, Inc., a Hauppauge, N.Y.-based mail-order prescription company that brought units of common stock and warrants public last August at $8. Today the units trade over-the-counter at 20.

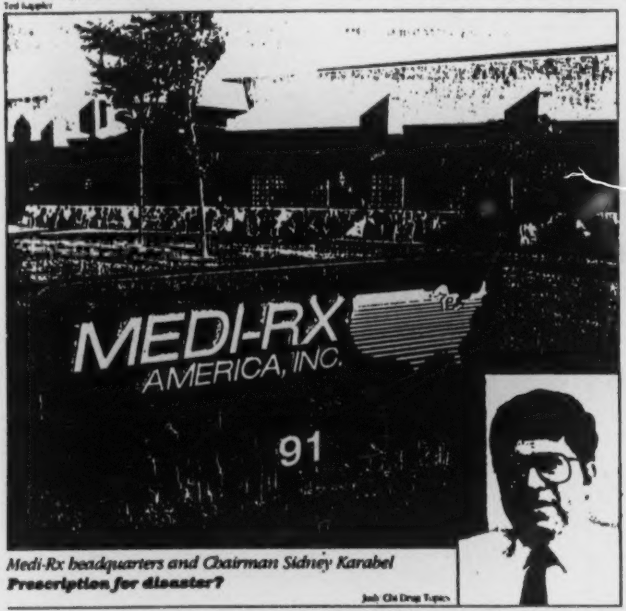
Medi-Rx hasn't made any money yet. It lost $885,000 in its most recent quarter on revenues of $840,000. Never mind, the future looks good to investors: Medi-Rx has signed up 1.3 million customers, among them health plans of the U.S. Steel Workers, the United Mine Workers, U.S. Postal Workers and a segment of Metropolitan Life of New York's health insurance customer base.

However, if investors and customers knew more about Medi-Rx' president, Burton Zweigenhaft, 33, or its chairman, Sidney Karabel, 39, they might not be so eager to join the Medi-Rx team. There's much more to the tale than what's in the company's prospectus, sales material or 10-K.

What the reports don't tell you is that Medi-Rx management has been linked to the drug diversion business, a huge, international submarket in pharmaceuticals that may be either counterfeit, stolen or adulterated. Zweigenhaft, one of Medi-Rx' founders, has been associated in the recent past with companies identified in congressional testimony as major drug diverters. Neither he nor Karabel would talk with FORBES about the company. Karabel alibied that an interview might seem too promotional, given a big corporate announcement that was pending.

What exactly is drug diversion? A drug has been diverted if it has not been obtained directly from the manufacturer or from an authorized distributor. Diverted drugs can be subpotent, outdated or, worse, outright ineffectual counterfeits.

The diversion market is supplied from a range of sources. For example: drug samples that are supposed to be dispensed by doctors but are sold instead to wholesalers; pharmaceuticals that are produced in the U.S., sold to foreign buyers at cheaper prices and then reexported to this country to be sold at our usually higher wholesale prices; foreign-produced goods that are relabeled or repackaged and perhaps reconstituted; and stolen or counterfeit merchandise.



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Medi-Rx headquarters and Chairman Sidney Karabel
Prescription for disaster?

[illegible] Drug Topics

The dangers of drug diverting first came to the government's attention in 1984, when shipments of counterfeit Ovulen-21, a birth control pill, were found in the U.S. Some 2 million pills, half of which were placebos and half of which had a subpotent amount of estrogen in them, were found to have been manufactured in Panama and sent to various distributors in the States. Several women got pregnant before the fakes were discovered.

In response to this problem, Representative Ron Wyden (D–Ore.) is sponsoring a bill called the Prescription Drug Market Act which will ban the reimportation of drugs produced in the U.S., restrict the distribution of drug samples and require wholesalers to be licensed and accountable for their handling of prescription drugs.

Before he founded Medi-Rx, drug diversion was Zweigenhaft's game. One government official calls Zweigenhaft "the reigning world champion of drug diversion."

In the past seven years, Burton Zweigenhaft has run or been employed by five companies other than Medi-Rx. Three of the five have been identified in congressional testimony as drug diverters, and another was a subsidiary of a company named in the same testimony. Two of the five are cited as having dealt in counterfeit drugs during the years he ran them or was employed by them. And, in the last company Zweigenhaft ran, identified in the testimony as one of the top five drug diverters in the nation, Sidney Karabel worked with him.

Zweigenhaft started his first company, Sundance Distributors, Inc., in Oceanside, N.Y. in 1976, when he was 22. On Nov. 19, 1980 the company, a health and beauty aids distributor, filed for Chapter 7 bankruptcy with $900,000 in unsecured debts.

Two months later Zweigenhaft joined Interstate Cigar Co., a privately held wholesaler named in congressional testimony as a drug diverter. He left Interstate in 1983 to form Data Medics Group, a subsidiary of Farmedics, which was owned by Martin Thuna. It folded when Thuna was caught stealing health and beauty aids. He is currently serving 28 years in prison for the felonies.

After leaving Data Medics, Zweigenhaft joined Quality King, Inc., a Deer Park, N.Y.-based wholesaler, as a buyer. It was during this time that the counterfeit Ovulen-21 birth control pills surfaced. A batch was on its way from Panama to Quality King in New York while Zweigenhaft was employed there. Before they could reach Quality King for distribution, U.S. Customs intercepted them.

Zweigenhaft started Habarx Distributing Corp. in November 1984. Less than two years later Habarx under Zweigenhaft had become one of the top five drug diverters in the nation, say government investigators. According to congressional testimony, $670,000 worth of counterfeit-labeled Pipracil, an antibiotic, was received and disseminated by Habarx and two other Long Island concerns.

During the Habarx years, Zweigenhaft met up with Karabel, a graduate of the Harvard Business School, who is now Medi-Rx' chairman. Although Karabel's association with Habarx is not mentioned in the Medi-Rx prospectus, there is some evidence that he had dealings with the drug diverter. Habarx terminated its registration with the New York State Pharmacy Board on June 30, 1986. Its telephone has been disconnected, but dissolution papers have not been filed with the state. The federal government is now contemplating bringing legal proceedings against Habarx.

Medi-Rx America, Inc. was incorporated in 1985, while Habarx was still operating. The two companies shared office space. On Mar. 5, 1986, according to a congressional staff report, Habarx took delivery of some diverted merchandise at 91b Cabot Court in Hauppauge, N.Y.—the same building that now serves as Medi-Rx' headquarters and dispensing facility.

Medi-Rx is Zweigenhaft's first public company. So far, there is no proof that Medi-Rx deals in diverted merchandise. But if Zweigenhaft is still operating other companies in the drug diversion business—Habarx, for example—possession of an enormous and anonymous mail-order customer base, such as Medi-Rx', would be a natural. As one industry observer notes, "Prescriptions by mail? What a wonderful way to get rid of diverted drugs."

Caveat emptor. ■

Medco Client Letters

August 6, 1987

Senator James R. Sasser
Chairman
Subcommittee on Governmental
  Efficiency, Federalism
  and the District of Columbia
United States Senate
Washington, D.C. 20510

Dear Senator Sasser:

On December 1, 1984, General Motors Corporation and the United Automobile Workers of America introduced a voluntary Mail Order Prescription Drug Program (MOPD) for our active and retired enrollees and their dependents, a total of more than 2 million people nationwide.

Under the Program provisions, GM/UAW enrollees may receive up to a 90-day supply of covered prescription drugs for a $2 copayment. Our Traditional Program generally limits the days' supply to 34 days for a copayment of $5 per prescription ($3 copayment for enrollees in PPO option). In general, the payment under the Program is that of acquisition cost plus dispensing fee minus employe copayment.

The Program, thus far, has offered our people a cost-effective, quality alternative to the Traditional Prescription Drug Benefit Program, as evidenced by the 980,700 prescriptions filled in 1986.

The Program is targeted to individuals who may be taking a maintenance prescription drug for a chronic condition. Our data reflects that acute prescription needs are still filled by a local pharmacist. In 1986, about 8% of all prescriptions reimbursed under the General Motors Prescription Drug Program were filled through the mail order system.

Our retiree population, in particular, has indicated that MOPD offers them the convenience of home delivery with the added incentive of a lower copayment. In addition, the Corporation realizes cost savings because fewer dispensing fees are necessary, and the acquisition cost of the drugs are lower under MOPD as a result of volume purchasing arrangements. It is our opinion that programs, such as MOPD, are an example of how enrollees and employers can benefit from cost containment programs which are innovative and quality based.

Because of the success of the Program, GM and the UAW will continue to offer MOPD as a cost-effective, quality alternative for our population.

Sincerely,

David C. Beier
Assistant Director
General Motors Department
UAW International Union

Beach B. Hall
Assistant Director
Health Care Benefits
Employe Benefits
Personnel Administration
and Development Staff

GOVERNMENT EMPLOYEES BENEFIT ASSOCIATION, INC.
GOVERNMENT EMPLOYEES MUTUAL BENEFIT ASSOCIATION, INC.
P.O. BOX 206 ANNAPOLIS JUNCTION, MARYLAND 20701
AREA CODE (301) 688-7912 or 621-8880

August 03, 1987

Honorable Jim Sasser
Suite 363
Russell Senate Office Building
Washington, DC 20510-4201

Dear Senator Sasser:

The Government Employees Benefit Association has been requested to communicate to you our overall opinion of the Mail Service Prescription Drug Program offered through National Pharmacies, Inc.

The program commenced on January 1, 1986 and has been very well received by our members. Approximately 12,000 prescriptions have been dispensed under the program with very few problems or complaints regarding accuracy or quality of service. In fact, the Mail Service Program has proven to be the most popular of health care benefits offered to our members.

The Government Employees Benefit Association is very pleased with the National Pharmacies' Mail Service Program.

Sincerely,

Renee Leskiw

Renee Leskiw
Administrator

sh

Mountain Bell
A US WEST COMPANY

1801 California, MSC 1140
Post Office Box 1884
Denver, Colorado 80201
Phone (303) 896-2770

Paul Tracy
Staff Manager
Benefits

August 3, 1987

The Honorable Jim Sasser
Suite 363
Russell Senate Office Building
Washington, D.C. 20510-4201

Dear Senator Sasser:

National Pharmacies, Inc. has been the mail service prescription drug provider for the Mountain Bell since June, 1985. National Pharmacies has filled more than 122,000 prescriptions for employees and retirees of Mountain Bell. We based our decision to contract with National Pharmacies for this service not only on price, but on quality of service, reputation and years in this industry.

Mountain Bell is very pleased with the quality and performance of National Pharmacies' mail service program. To date, National Pharmacies' record for accuracy in dispensing prescriptions to our employees has been exemplary. Our mail service prescription drug benefit is a very popular benefit amongst our employees and retirees.

Sincerely,

Paul R. Tracy

Executive Director
William R. Hutton
Washington, DC

National Council
of Senior Citizens

President
Jacob Clayman
Silver Spring, MD

925 Fifteenth Street, N.W. • Washington, D.C. 20005 • (202) 347-8800

August 5, 1987

The Honorable James Sasser
Chairman, Subcommittee on Government
Efficiency, Federalism and the
District of Columbia
363 Russell Senate Office Building
Washington, D.C, 20510

Dear Mr. Chairman:

It has come to our attention that your Subcommittee plans to hold hearings to consider certain aspects of safety and soundness of mail-order pharmacy operations. In this connection, our experience may be of interest to your Subcommittee.

In 1977, National Pharmacies, now a subsidiary of Medco, at our request, agreed to supply our membership with prescription drugs by mail, which would offer monetary savings, as well as convenience, both of which are needed by the elderly. During this period, the thousands of our members per month, who have taken advantage of this service, have generally been the poorest, and the savings derived from purchasing drugs by mail have been significant. Since many of these members are frail, the convenience of having their prescriptions filled without having to leave their homes--particularly in very hot or cold weather--is very important for the elderly. In addition——and this is very important——not a single complaint about safety, effectiveness or service has ever come to our attention.

For the past half century, there have been many attempts to eliminate competition at the retail level, such as resale price maintenance (euphemistically called "fair trade" laws). We suspect that attempts——usually clothed as public interest concerns——are still being made.

Sincerely,

William R Hutton

William R. Hutton
Executive Director

WRH/G/rb17

OPEIU 2 (AFL-CIO)

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Secretary-Treasurer, Jack Turner, Detroit, Michigan General Counsel, Robert J. Mozer, New York

The Police and Firemen's Disability and Pension Fund
230 East Town Street/Columbus, Ohio 43215-4650/(614) 228-2975

L. PAUL ROSS, *Executive Director*

August 3, 1987

The Honorable Jim Sasser
Suite 363
Russell Senate Office Building
Washington, D.C. 20510-4201

Dear Senator Sasser:

The Police and Firemen's Disability and Pension Fund of Ohio has provided mail service prescription service to our members through Medco (or an affiliated company) since April 1981. During that time over one-half million prescriptions have been dispensed.

We can attest that their record of quality and accuracy has been exceptional. Both the pension administration and our members believe that this program is a much needed service for our retirees and their dependents.

Very truly yours,

L Paul Ross

L. Paul Ross
Executive Director

LPR/mil

Mailing Address:
1019 No. Royal St.
Alexandria, Va. 22314-1596
Telephone: 703-683-1664

August 4, 1987

Honorable Jim Sasser
Suite 363
Russell Senate Office Building
Washington, DC 20510-4201

Dear Senator Sasser:

National Pharmacies, Inc., provides mail service prescription drug benefits to more than 37,000 members covered under the Postmasters Benefit Plan. To date, approximately 98,784 prescriptions have been dispensed under the Program.

Prior to selecting National Pharmacies as the mail service prescription drug provider, the Postmasters Benefit Plan conducted a comparison of services offered by the various providers. Based on our overall experience and general popularity of the Program, we are convinced that National Pharmacies operates an efficient operation which provides the convenience and cost savings desired by our members.

Sincerely,

Shirley R Harris

Shirley R. Harris
Administrator

SRH/KAH/ljg

POSTMASTERS BENEFIT PLAN®
SPONSORED BY THE
NATIONAL LEAGUE OF POSTMASTERS

PUBLIC EMPLOYEES RETIREMENT SYSTEM OF OHIO
277 EAST TOWN STREET COLUMBUS, OHIO 43215
TELEPHONE (614) [illegible]

August 3, 1987

When replying please give your Social Security number. This is now used to identify your account in PERS

The Honorable Jim Sasser
Suite 363
Russell Senate Office Building
Washington, D.C. 20510-4201

Dear Senator Sasser:

The mail service prescription drug program offered to the Public Employees Retirement System of Ohio has been a popular benefit since the inception of the program in 1981. Over three million prescriptions have been dispensed to our members by National Rx, a Medco mail service pharmacy.

We have received very few complaints from retirees considering the tremendous utilization of the program. We are satisfied that National Rx operates a quality mail service pharmacy.

Yours very truly,

RDMyers

Richard D. Myers
Assistant Director

RDM/sab

WILLIAM S. McLAUGHLIN
Executive Director

RICHARD D. MYERS
Assistant Director – Benefits

ROBERT A. McLAUGHLIN
Assistant Director – Investment Officer

RICHARD E. SCHUMACHER
Assistant Director – Comptroller

EDWARD T. HALE
Manager – Data Information Systems

School Employees Retirement System

45 NORTH FOURTH STREET
COLUMBUS, OHIO 43215-3634
TELEPHONE (614) 221-6653
INVESTMENTS (614) 221-7012

THOMAS R. ANDERSON
Executive Director

DEPARTMENT DIRECTORS

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Management Information Services

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Investments

JOHN W. FRANK
Accounting & Control

ROBERT E. HARTSOOK
Member Services

RITA M. VOLPI
Planning & Development

August 4, 1987

The Honorable Jim Sasser
Suite 363
Russell Senate Office Building
Washington, D.C.   20510-4201

Dear Senator Sasser:

The School Employees Retirement System has been requested to provide you with our opinion of the quality of service provided to our retirees by Medco. We have been a customer of National Rx, an affiliated company of Medco, since 1981. Our retirees are pleased with the service provided by the mail service prescription drug program.

We have no complaints with the quality of service provided by Medco.

Respectfully,

Robert E. Hartsook

Robert E. Hartsook
Director, Member Services

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OF OHIO 275 EAST BROAD STREET, COLUMBUS, OH 43215-3771
TELEPHONE (614) 227-4090

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J. RICHARD ZIMMERMAN, Member Benefits

STAFF COUNSEL, CYNTHIA E. HVIZDOS

August 4, 1987

Honorable Jim Sasser
U. S. Senate
363 Russell Senate Office Bldg.
Washington, D.C. 20510-4201

Dear Senator Sasser:

National Rx Services, a subsidiary of Medco Containment Services, Inc., has provided a mail service prescription drug program to the State Teachers Retirement System of Ohio since 1981. In that time they have dispensed over 2 million prescriptions to our members. The mail service program is a very popular benefit, especially in light of the convenience it offers the elderly and disabled.

We are very pleased with the mail service program provided by Medco, and are confident that we are offering a safe, accurate, economical and quality minded service to our participants.

Respectfully,

C. James Grothaus
Executive Director

CJG/1

cc: Honorable John Glenn

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FRANKLIN B. WALTER
SUPERINTENDENT OF PUBLIC INSTRUCTION

OPM MATERIAL PERTAINING TO ITS MAIL-ORDER PLAN

United States
Office of
Personnel Management Washington, D.C. 20415

In Reply Refer To Your Reference

SEP 10

Honorable Jim Sasser
Chairman, Subcommittee on Government
Efficiency, Federalism, and the
District of Columbia
Committee on Governmental Affairs
United States Senate
Washington, D.C. 20510

Dear Senator Sasser:

At the subcommittee hearing on August 6, 1987, you requested that we review OPM files and furnish the Committee with any materials that were presented to OPM staff at meetings or other presentations by mail order drug companies from 1982 to the present.

We found an assortment of informational materials (fliers, pamphlets, etc.) on mail order drug programs in the files of our insurance programs staff. We also determined that a presentation was made in 1984 by representatives of Medco Containment Services, Inc. Which, if any, of the informational materials in the file were associated with that meeting is unclear. While some of the informational materials deal with mail order drug programs of other vendors, I find no record of any other meeting or presentation.

I am also forwarding a copy of materials given to our actuarial staff in the spring of this year by representatives of the Medco Group. This entirely unsolicited material was provided in connection with a study Medco proposed to undertake on the cost effectiveness of mail order drug programs. We had no interest in their proposed study and have made no use of the material. Please note that this material is marked confidential and not to be distributed or made available without their permission.

Lastly, I have enclosed answers to some additional questions posed by Senator Heinz and Senator Mitchell which were transmitted to us following the subcommittee hearing.

Sincerely,

Jean M. Barber
Jean M. Barber
Associate Director
for Retirement and Insurance

MEDCO CONTAINMENT SERVICES, Inc.
491 Edward H. Ross Drive, Elmwood Park, NJ 07407
(201) 791-8200

October 5, 1984

Mr. George MacWhorter
Deputy Assistant Director
Office of Insurance Programs
Office of Personnel Management
P.O. Box 436
Washington, DC 20044-0436

Dear Mr. MacWhorter:

As you are probably aware, a number of the Federal Employees Health Benefit Programs and their participating organizations are considering the integration of a mail service prescription drug option for their participants. Medco Containment Services, Inc.'s subsidiary, National Pharmacies is the leader in this field. At your convenience, we would appreciate the opportunity to put on a presentation for you and any of your staff who would be interested in the following:

1. How a mail service prescription drug program works.
2. The specifics of the cost containment economics of such a program.
3. Why is a mail service prescription drug program an improvement in a prescription benefit.
4. The quality control aspects of such a program which insures its dependability and reliability.

Such a presentation would improve your staff's knowledgeability regarding this and other cost containment products and services which are now available to employee organization plans.

Please give me a call at area code 201-791-8200 so that we can discuss this further.

Enclosed is some basic information about National's Mail Service Prescription Drug Program.

Sincerely,

MEDCO CONTAINMENT SERVICES, INC.

James V. Manning

James V. Manning
Executive Vice President
Finance and Administration

Jim Manning
Thurs, Nov 29
10:30 a.m.

(45 min. slide present)

Noted!!

MEMBER BENEFIT SERVICES™
4200 WISCONSIN AVENUE, N. W.
WASHINGTON, D. C. 20016-2199

TELEPHONE
(202) 244-5878
TELEX 89484

February 15, 1985

RECEIVED
FEB 20 1985

Mr. Ronald Lancaster
Acting Chief
Employee Organization Plans Division
Office of Personnel Management
P.O. Box 707
Washington, DC 20044

Dear Mr. Lancaster:

This is to make a suggestion concerning this year's FEHBP "call letter" requesting benefit change proposals for the 1986 contract year. Also, please be advised that I have been retained by National Pharmacies, Inc. to represent them to the various plans in the Federal Employees Health Benefits Program.

I believe a well-designed mail order prescription drug program can represent an effective cost-containment tool for employee benefit plans. Plan savings can be achieved because of the following factors:

1. Prescriptions are furnished to plan enrollees through a preferred wholesale provider without retail price markups.
2. Dispensing of generic over brand name drugs is maximized.
3. Individual claims processing and the mailing of checks associated with patient reimbursement is eliminated.
4. State-of-the-art eligibility and drug screening minimizes potential abuses.
5. Sophisticated utilization reports inform plans in more than a dozen meaningful ways how their members utilize drugs and thus provide the potential to manage such costs.
6. Furnishing 90-day supplies for patients on maintenance drug programs minimizes repetitive dispensing fees that retail purchasers normally incur.

Mr. Ronald Lancaster
February 15, 1985
Page Two

Individual Federal employees can also benefit from a well-managed and designed mail order prescription drug program. Consider the following:

1. Potentially, employees' out-of-pocket costs are reduced and/or improved benefits are perceived.
2. Mail-order dispensers can maintain better quality control over prescriptions than typical drug store chains. For instance, National Pharmacies screens prescription orders at least four times by registered pharmacists.
3. Mail-order dispensers furnish generally better drug information to employees than the typical multipurpose drug store chain.
4. Employees on continuous maintenance drugs will appreciate the convenience of regular reliable home delivery.
5. By matching prescriptions against patient profiles and histories, medical problems resulting from drug interactions are avoided.

Today, prescription drugs can equal up to 10% of a health plan's costs. Managing these costs through a central preferred provider concept can reduce overall plan costs while enhancing benefits and service to enrollees.

I would like to take the liberty of suggesting that OPM in its annual "call letter" request the plans in the Federal Employees Health Benefits Program to investigate and consider mail order prescription drug programs for their 1986 benefit packages.

Sincerely,

Arthur Tollick
President, Member Benefit Services

MEMBER BENEFIT SERVICES

4200 WISCONSIN AVENUE, N. W.

WASHINGTON, D. C. 20016-2199

TELEPHONE

(202) 244-5678

TELEX 89484

RECEIVED

APR 10 1985

April 2, 1985

Mr. Ronny B. Lancaster, Chief
Employee Organization Plans Division
Office of Insurance Programs
U.S. Office of Personnel Management
Washington, DC 20415

Dear Ronny:

I appreciate your letter of the fifteenth concerning the 1986 call letter. I have made or am hoping to make a presentation to each of the employee organization plans in the Federal Employees Program. So far, the response has been quite positive, particularly with regard to the cost containment aspects of a mail order prescription drug program.

I trust my original letter of February 15, 1985, to Kevin Burns was not misunderstood. I certainly was not suggesting OPM recommend any particular provider. There are certainly several fine mail order vendors.

However, I strongly believe the mail order drug concept has excellent cost containment potential. Ed Von Hoene at Postmasters mentioned to me the other day that they are already experiencing savings.

Could OPM suggest that the various plans consider the benefit in the forthcoming cost containment letter in the same manner that OPM has previously recommended hospice benefits, second opinion programs or other provider arrangements?

Sincerely,

Arthur Tollick
President, Member Benefit Services, Inc.

AT/we

CNE

Mr. Arthur Tollick, President
Member Benefit Services
4200 Wisconsin Avenue, NW
Washington, D.C. 20016-2199

Dear Mr. Tollick:

This is in reply to your letter to Kevin Burns dated February 15, 1985, regarding the inclusion of a specific item in the call letter for 1986 benefits under the Federal Employees Health Benefits Program (FEHBP).

OPM remains committed to expanding and improving the cost containment initiatives of all Plans. However, we feel that it is inappropriate to focus special attention or interest on any one potential cost saving measure or provider of such services. Therefore, we suggest that you contact the Plans individually to discuss the mail order prescription drug program offered by National Pharmacies, Inc. Each Plan can then assess the value of incorporating a mail order program in their own cost containment initiatives for 1986.

Thank you for your interest in the FEHBP and in particular OPM's cost containment efforts within the Program.

Sincerely,

Ronny B. Lancaster, Chief
Employee Organization Plans Division
Office of Insurance Programs

CNE:LJWaligora:mew/wmc 3-15-85
Action:

OCT 17 1985

MEMBER BENEFIT SERVICES™
4200 WISCONSIN AVENUE, N. W.
WASHINGTON, D. C. 20016-2199

TELEPHONE
(202) 244-5878

TELEX 89484

October 15, 1985

Mr. George M. MacWhorter
Insurance Programs
Office of Personnel Management
P.O. Box 707
Washington, D.C. 20044

Dear George:

I thought you might be interested in this article I came across on drug costs.

Sincerely,

Arthur Tollick
President

AT/dhc

Enclosure

How are things?

IN THE MARKETPLACE

RADICAL SURGERY FOR DRUG COSTS

The forerunner of one of the hottest new areas of health care: mail order medicine.

Few companies would ever turn to the U.S. Post Office for answers on to how to operate more efficiently, but that is exactly what Glyco, a small chemical manufacturer in Connecticut, recently did after absorbing another 30-percent annual increase in employee health care costs. To reduce costs the company could have taken away some health care benefits or asked their employees to pay a greater share of the costs. Instead of incurring employee wrath, however, the company decided to add a new benefit altogether. Starting July 1, Glyco's employees were given the option to buy their drug prescriptions through the mail. The employees pay no deductible, and the company has been told by America's Pharmacy, the company offering the mail service program, that it can expect substantial savings in prescription drug costs.

Once shunned as an impersonal and inappropriate method to market medical products, mail order is now being greeted with the same enthusiasm among health care customers as it has been for years in the consumer product business. Laboratory products, dental items and physical-therapy products have long been sold through the mail. Now, however, with growing pressures on health care companies to reduce costs, mail order is being looked at by other businesses as a means of reaching the end user less expensively, without sacrificing the quality of service. Indeed, some observers estimate the medical mail order business increased 50 percent last year to $500 million.

What is driving the growth in the mail order pharmacy business is not the novelty of the program, but a new purchaser, the employer. Mail-order pharmacies have been in existence for over 25 years, but it is only in the past several years that the employer, faced with prescription drug prices that have been increasing two times the rate of all other health care expenditures, has suddenly taken notice and begun to offer the program as part of his employee benefit package. Explains Frederick Klein, senior vice-president at Medco Containment Services, the largest for-profit company selling mail-order prescription services, "Now we are really on a roll. This is the hottest thing in employee benefits." Indeed, much of the excitement about the mail-order pharmacy business and mail-order medicine in general has been due to Medco's outstanding performance *(see sidebar,* "The Industry Leader"*)*.

Today there are over 12 organizations in the mail-order pharmacy business, ranging in size from the Veterans Administration, which mails over 20 million prescriptions a year throughout the U.S., to a number of small organizations that rely on just a few customers for most of their business *(see Table 1)*. The V.A. and the American Association of Retired Persons, the two largest, are both non-funded programs in which those using the service pay for their prescriptions out of their own pocket. Most of the for-profit companies, however, target their services to funded plans where payment is assumed by the employer, who offers the program as an alternative to major medical and non-medicaid card programs *(see Table 2)*.

A Volume Business

In concept, mail service pharmacies are no different from any other mail-order business that derives its profits by selling a large volume of selected items, using a highly automated system of order processing and record-keeping. Drugs are bought in volume at about 10 percent less than the average wholesale price (AWP). And they are sold in volume — generally three- to six-month prescriptions instead of the one-month supply or less dispensed by the local pharmacist, thus saving the employer the dispensing fees and processing charges and the patient his co-payments *(see Table 2)*. These multiple-month prescriptions are ideally suited for patients who are receiving maintenance therapy for such diseases as hypertension, ulcers, asthma, diabetes and arthritis, diseases that afflict a small percentage of the U.S. population but nevertheless account for about 70 percent of all prescriptions.

Besides the savings gained from the larger prescriptions, employers can also save money on the cost of the drug itself. Because of the better prices that mail-order companies pay for their drugs, combined with better inventory management, drug prices to the consumer usually exclude the retail markup that the pharmacist charges. Another big contributor to the difference in prescription costs is the substitution of generics for branded drugs wherever possible. About 40

ORGANIZATIONS OFFERING MAIL ORDER PHARMACY SERVICES

Table 1

Company	Primary customers (*funded/ non-funded*)	Estimated Rxs filled per week	Dispensing plant locations	Major Customers
Veterans' Administration	NF	385,000	172 medical centers, 220 outpatient clinics nationwide	U.S. Veterans
American Association of Retired Persons	NF	115,000	CA, CT, IL, WA, PA, NV, OR, MO, IN, TX	17 million members of AARP
Medco Containment Services	F	80,000	NJ, OH, CA	General Motors, United Technologies, Occidental Petroleum, ALCOA
Health Care Services	F	25,000	PA	Ford Motor, Goodyear
Express Pharmacy Services (Thrift Drug/J.C. Penney)	F	18,000	PA	General Motors, Pitney Bowes, Rockwell
America's Pharmacy (Caremark)	F/NF	10,000	IA, MO	Burroughs, Monsanto, National Arthritis Foundation
Employee Pharmaceutical	F	3,500	NY	Various unions
Prescription Delivery Systems	F	2,000	PA	Uniroyal, Firestone, Snap-On Tools, Cooper Tire and Rubber
Walgreens	F/NF	1,000	AZ	Arizona Physicians IPA, companies, HMOs
Mail Med (Prescription Plan Service)	F/NF	1,000	FL	Unions, companies, public
Family Pharmacists of America	NF	<1,000	SC	Mature Outlook (Aetna/Sears), Days End of America
Home Pharmacy	NF/F	<1,000	IL	—

percent of all prescription drugs could be prescribed generically at an average cost of half to two-thirds that of branded products. But whereas community pharmacies make substitutions in maintenance medications about 8 percent of the time, mail service pharmacies substitute at rates between 15 and 30 percent, a difference that can cut prescription costs dramatically.

There are other benefits as well. Since all prescriptions are dispensed from one location, there is a detailed record of all drugs prescribed for all patients. This reduces the opportunities for drug abuse that can occur under other programs in which the patient is free to visit numerous pharmacies to get his prescriptions filled.

A 5- to 50-Percent Savings

However, some of the benefits of ordering drugs through the mail have to be couched in qualifications. As health benefit consultants and companies in the mail-order business point out, the actual savings in prescription costs can vary considerably — from as little as 5 percent to as much as 50 percent under the best of circumstances. The reason for this large disparity is due to a number of factors, including the structure of the company's benefit program, the age and health of the company's employees, the percentage of employees on maintenance drugs and the percent who participate in the program.

Providing a three- to six-month prescription can save a company money but only if the entire prescription is used, and used by a qualified employee. Citing the results from a study his company completed on the mail service business, one executive said, "We found that a very significant portion of drugs prescribed in more than 90-day quantities were absolutely wasted — that medication changed, that people just stopped taking the medication before they should have, or that people left their employ during their six-month prescription when they would normally have lost their eligibility." The result is that any savings in fees to the pharmacist can be easily lost in the extra money spent on the long-term supply of the drug.

MEDCO: THE INDUSTRY LEADER

For a barometer on the health of the mail-service pharmacy business, the place to look is Medco Containment Services, a 78-percent owned-subsidiary of Porex Technologies, which estimates it has a 70-percent share of the employer funded prescription market. As recently as five years ago sales were languishing around $9 million. Since 1980, however, sales have grown at an average annual rate of 120 percent, reaching an estimated $66 million for its June 30, 1985 year end.

One important reason for Medco's success is its chairman, president and CEO, Martin J. Wygod. Well-connected on Wall Street where he ran his own investment firm, Wygod in the late 70's put together the highly successful Glassrock Medical home health care business which was then sold to The BOC Group, PLC. Sensing even better growth prospects from mail service medicine, Wygod created Medco from the 1983 acquisition of two mail order businesses owned by APL Corporation. Says Harri Taranto, a vice president of Channing, Weinberg, a consultant to Medco, "Wygod has an uncanny eye for uncovering the unexploited opportunity and then singlemindedly pursuing it. What's exciting about Wygod, and therefore about Medco, is the focused energy of its management style. That's what has made this company what it is and gives it its uncommon growth prospects."

Currently Medco fills close to four million prescriptions a year for over 500 corporations. Participants send their written prescriptions (with any required co-payments) to one of three designated dispensing centers, which check for eligibility information as well as for potential adverse reactions with other drugs the patients may be taking. Each company sponsor receives a monthly statement accounting for the prescriptions filled during the previous 30 days and is given access to various data-reporting services and drug-education programs. Each sponsor of a mail service benefit program receives a monthly statement accounting for the prescriptions filled during the previous 30 days and has access to various data-reporting services and drug-education programs.

Selling pharmaceuticals through the mail is currently Medco's only business, but according to Taranto the company is ideally positioned to act as a sales agent for other health care products used by an employee but paid for by an employer or other sponsor. Says James Manning, Medco's executive vice president, the computer maintained patient profiles constitute a ready-made information base on other health care products that participants might want to purchase through the mail (diabetic products, for example, for those ordering insulin).

Moreover, because Medco's sales contacts are corporate benefit directors, the company has a potential entree to sell health benefit programs such as HMOs and PPOs. Last January, PAID Prescriptions joined Medco under the Porex umbrella, adding a plastic-card program to complement Medco's mail-order business. With over $10 million in short-term investments and a substantial line of credit, Medco has made it clear that future acquisitions are an integral part of the company's growth plans.

12 from 1-15 →

Ten years ago, prescribing an extra month's prescription would not have been as costly. The cost of an average prescription was between $4 and $5, and dispensing fees averaged about $2. But today a prescription costs about $11, and the dispensing fees have risen to only $3.10; one extra month's prescription wipes out more than three months of dispensing fees.

The competition for business among local pharmacies in the area where a company is located is also important in determining the difference in the price of a drug purchased through the mail and from the pharmacy. Retail drug prices on the average are marked up between 35 and 45 percent above the drug's average wholesale price. But often pharmacists will price some of the larger-selling drugs at cost, using them as loss leaders to attract customers into their store to buy other health care sundries. There can, therefore, be instances in which a drug may be purchased less expensively through a pharmacy than through the mail.

Another variable is the amount of the patient's co-payment. Companies often find that to induce employees to use mail-order programs, they have to reduce or sometimes waive the co-payment altogether. At Ford Motor, for example, employees purchasing their prescriptions through the mail pay a $2 co-payment for a three-month prescription whereas those using major medical have to pay $5 every time they get a one-month supply. Even with this financial incentive, only 6 percent of Ford's eligible employees order their drugs through the mail.

Little To Lose

Nonetheless, benefit managers have little to lose by offering a mail service program. Says Gary Sekulski, senior vice-president at Medco, "Typically one-third of the employees generate 80 percent of the total claims, so even 20 percent participation in a mail-order program is outstanding."

If both employees and employers are the winners with mail order, the losers are the local pharmacists. The National Association of Retail Druggists (NARD), which represents 30,000 independent pharmacists and which is the most vocal opponent to mail-order pharmacies, charges that by denying patients the opportunity to consult personally with their pharmacist on the proper use of their medications, mail order is a threat to the

ARISON OF DRUG BENEFIT PROGRAMS

Table 2

	Major Medical Three 30-day Rxs	Card Programs Three 30-day Rxs	Mail Order One 90-day Rx
Ingredient Cost[1]	$41.00	$29.25	$29.25
Dispensing Fee[2]	—	10.50	1.45
Claim Processing Fee	5.00	1.95	—
Total Charge	$46.00	41.70	$30.70
Co-Payment	(9.00)	(6.00)	(3.00)
Net Cost to Employer	$37.00	$35.70	$27.70

[1] Retail price for major medical assuming a 40 percent mark-up, average wholesale price for card and mail order plans

[2] Average major medical and card dispensing fees $3.50 (30 days), mail order fees range from $.85 to $3.35. Major medical dispensing fees are included in the ingredient price the patient pays for the drug

public's health. Mail service companies point out that all patients are sent drug-information leaflets with their prescriptions and that if the patient has a question, he can call a toll-free number and speak with a registered pharmacist. The personal attention may be absent, but, says one observer, "Anybody who spends any time in the pharmacy sees how much consultation a patient gets from a pharmacist behind a glass-walled partition."

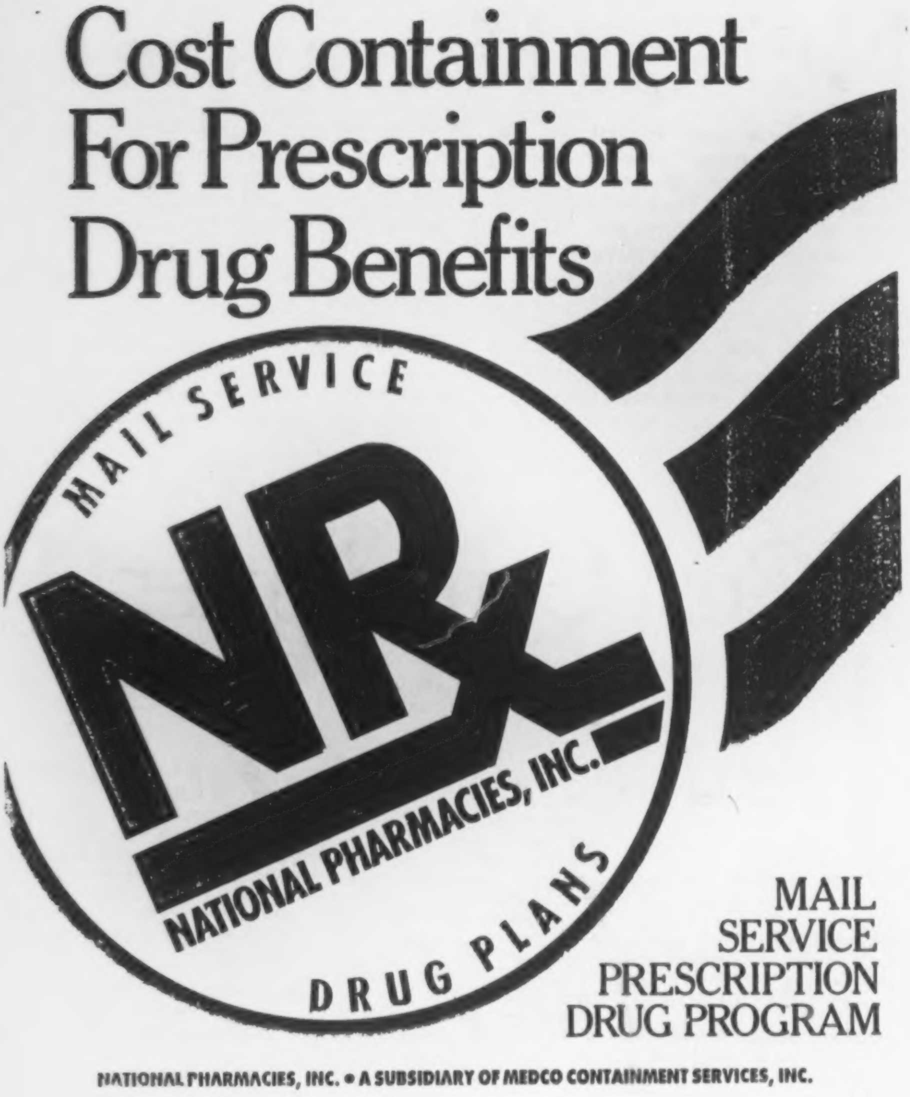
Yet what irks pharmacists the most, and where they feel they are at a competitive disadvantage, is in generic prescribing. Mail-order pharmacies have to abide only by the generic prescribing laws in the states where their filling operations are located — not by the individual laws of the states to which they are mailing prescriptions. Local pharmacy associations have reacted to what they perceive to be an unfair competitive advantage by petitioning their legislators to either ban mail-order pharmacies or to require them to abide by individual state dispensing laws. It is a move that discourages interstate commerce and that has not gone very far with the Federal Trade Commission. Pointing to the V.A.'s program and the 20 million prescriptions it mails every year, Leon Weisberger, vice-president of operations at Prescription Delivery Systems, notes, "If the federal government sets the precedent for mail order, it's a little hard for a state to overturn it."

New Competitors

These complaints by the independent pharmacists have not been echoed by the chain drug-stores. Although mail order is certainly a threat to a chain's business, prescriptions account for a smaller share of a chain's sales, on the order of 21 percent of sales as compared to 58 percent for the independent pharmacist. However, a more significant reason for staying mute on the subject is that mail order is a business a chain could easily get into itself. Two of them already have. Thrift Drug, a subsidiary of J. C. Penney, started its own program two years ago. Walgreens started its mail-order business last year, and Revco is considering one.

No doubt these companies are only the first of a number of firms that will be considering mail order as an attractive means of diversifying their business. But according to one industry participant, neither the chain drugstore nor the large mail service pharmacy will fit easily into the type of business to which they are accustomed. It requires "a totally different set of backup services than those being offered in the retail drug business," he says. And to look at it as being similar to any other mail-order sale to the consumer "is to look at it backwards because the initial sale is made with the corporate or association client. It's not the *Land's End* catalog business."

The difference also applies to the type of products being sold. Any product, either a drug or another health care product, that is unfamiliar to the end user or that requires some training to use would generally be difficult to sell through the mail. But as is the case in the prescription drug industry, most other health care products are well-established and the sales are typically replacement sales. In such cases, mail order may be just the answer for catering to the catalog-shopping, charge-by-phone tendencies of today's convenience shopper ■



Cost Containment For Prescription Drug Benefits

MAIL SERVICE
NRx
NATIONAL PHARMACIES, INC.
DRUG PLANS

MAIL
SERVICE
PRESCRIPTION
DRUG PROGRAM

NATIONAL PHARMACIES, INC. • A SUBSIDIARY OF MEDCO CONTAINMENT SERVICES, INC.

National Pharmacies:

More and more cost-conscious Benefits Managers are turning to mail service prescription plans in their effort to control rising Health Care costs. Once you know what we do, we think you'll agree that mail service is one of the simplest and most significant cost containment measures you can take.

WHAT WE DO: National Pharmacies saves you money. We provide prescription drugs by mail, as a supplement to existing prescription benefits, to those taking ongoing (maintenance) medication. *You* pay the lowest prices; *participants* save money too, and enjoy the convenience of home delivery. While most prescription plans merely provide methods of reimbursement, NATIONAL provides the full service and generates real dollar savings—not just cost shifting.

THE NEED: With Health Care costs continuing to soar, cost containment is no longer just a good idea; it's a necessity.
Prescription drug costs are consuming

A Cost Containment F

1

IMMEDIATE COST SAVINGS

National Pharmacies lowers the cost of prescription drugs several ways.

- **NO RETAIL MARK-UP:** Our prices are based on wholesale cost.

- **90 DAY SUPPLIES:** For on-going prescriptions, this saves repetitive administrative and dispensing fees that conventional 30 day plans incur.

- **MAXIMUM GENERIC DISPENSING:** NATIONAL's generic dispensing of maintenance medications *doubles* the U.S. rate. And, *you* save an average of 60% over brand name prices.

How do we contain our costs? By being a state-of-the-art dispensing facility: We purchase in volume and turn our inventory 18 times a year. We operate from large, central dispensing facilities so we never ship inventory to smaller branches. Automated counting equipment and sophisticated computers allow our pharmacists to dispense up to 4 times more prescriptions per day than a retail pharmacist.

There are no start-up costs at all. Savings begin with the very first prescription filled by National Pharmacies.

2

ADMINISTRATIVE EASE

No more individual claim processing and mailing of checks associated with patient or retailer reimbursement. With NATIONAL, you receive a single, detailed statement once a month. You issue only 12 checks a year.

We can integrate with your present prescription plan and custom design our program to meet your particular needs.

Prescriptions by Mail...

more and more of the Health Care dollar:

- 5 years ago, prescription drugs represented 5% of Health Care costs.
- Today, they often represent more than 10% of Health Care costs.

The key to our cost containment program is found in another statistic:
80% of the dollars spent on prescription drugs are for maintenance medications. By providing the most cost effective delivery system for the dispensing of maintenance medications, National Pharmacies can significantly reduce the cost of your prescription drug program.

WHO WE ARE: National Pharmacies Inc., the nation's leading mail service prescription drug company, has been #1 in this industry since mail service plans began. Our 200 plus clients include major corporations, unions, health and welfare trusts and retirement systems. With a solid record of service, innovation and dependability—at the lowest prices—we save more clients more money than any other provider of mail service prescription plans.

'lan You Can Count On

3

ELIMINATES COSTLY ABUSES

Do you ever wonder if you're paying for non-covered drugs? Or if you're providing benefits to ineligible dependents? Under your current plan can you be sure you're not paying for generic drugs at brand name prices? These and other common abuses associated with many prescription plans are eliminated with NATIONAL's program. With your eligibility list in our computer, we screen each prescription *before* it is filled. We don't dispense OTC items at all. And since our fees are based on published wholesale prices, when we dispense generics you get the *full savings.*

4

SUPERIOR SERVICE

NATIONAL is committed to superior customer service. We have toll free numbers and a staff of customer service representatives prepared to answer any questions participants might have about the program or their orders. Additionally, we have an educational leaflet program whereby the more commonly prescribed drugs are sent with accompanying literature explaining the proper use of the medication.

5

CLIENT REPORTS

Our innovative utilization reports are unique in the industry. We have developed the software to tell our clients in more than a dozen meaningful ways how their employees utilize our program. Breakdowns by date, age and sex. By location, department and division. By payroll classification, status, and medication name. Reports on how much we saved a client by substituting generics and how much *more* we could have saved them had their doctor permitted generic substitution. We even have a report that tells clients *by doctor,* who is and isn't allowing substitution.

WHY PARTICIPANTS LIKE MAIL SERVICE

- Less out-of-pocket cost
- No claim forms to file
- No waiting for reimbursement
- Security of a 90-day supply
- Medication is delivered to the door
- Toll-free customer service numbers

HOW MAIL SERVICE WORKS

1. The participant mails prescriptions in a pre-addressed envelope provided by NATIONAL. With the first prescription, the participant fills out a Patient Profile Questionnaire, which we computerize.

2. The prescription is screened, filled and mailed within 48 hours after it is received. In most cases, the medication will be received within 10 days from the date the order envelope is mailed to NATIONAL.

3. Enclosed with the medication are re-ordering instructions and a business reply envelope.

4. The sponsor or administrator receives a monthly bill on tape, microfiche or hard copy.

WHAT ABOUT EMERGENCY PRESCRIPTIONS? Obviously, there will be times when a participant needs a prescription immediately. On these occasions, prescriptions should be filled at a local pharmacy.

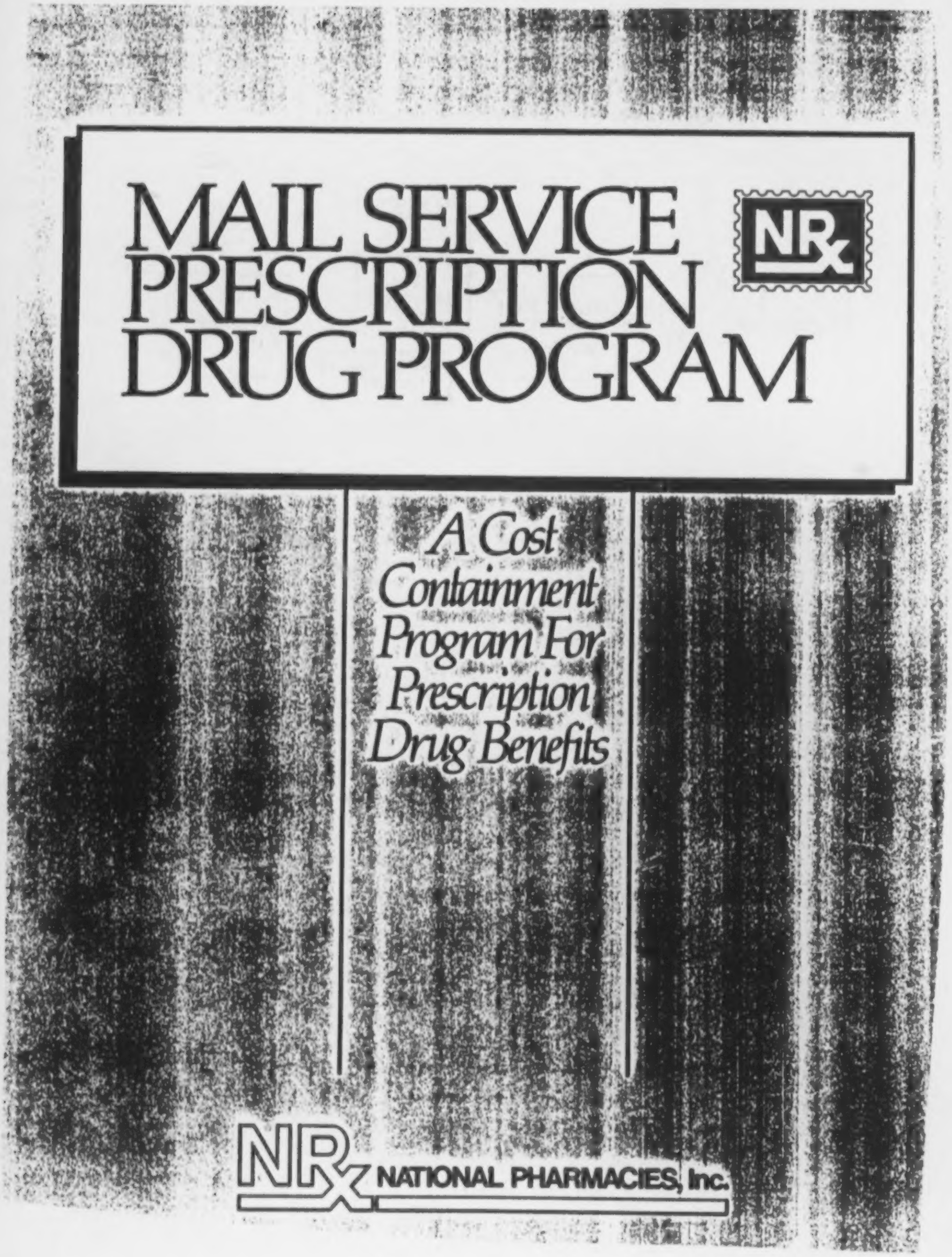
OVER 200 CUSTOMERS INCLUDING:

CORPORATIONS • BF GOODRICH • GENERAL MOTORS • GEORGIA–PACIFIC • METROPOLITAN LIFE INSURANCE • PAID PRESCRIPTIONS • WEYERHAEUSER • UNIONS • INTERNATIONAL LADIES GARMENT WORKERS • OIL CHEMICAL AND ATOMIC WORKERS • CARPENTERS HEALTH & WELFARE FUND OF PHILADELPHIA • UNITED AUTO WORKERS • UNITED TRANSPORTATION WORKERS UNION • RETIREMENT SYSTEMS STATE OF OHIO • STATE TEACHERS • PUBLIC EMPLOYEE • SCHOOL EMPLOYEE • POLICE & FIREMAN'S DISABILITY AND PENSION FUND • ASSOCIATIONS • NATIONAL COUNCIL OF SENIOR CITIZENS • RETIRED OFFICERS ASSOCIATION • VETERANS OF FOREIGN WARS •

HOW WE CAN WORK FOR YOU: Make an appointment with us, and we'll show you how we can decrease your prescription benefit cost. Call our Sales Department at our New Jersey Headquarters (201) 791-8200. Because cost containment is more than just a good idea; it's a necessity.

NATIONAL PHARMACIES, INC. 491 Edward H. Ross Drive, Elmwood Park, N.J. 07407 (201) 791-8200

• A SUBSIDIARY OF MEDCO CONTAINMENT SERVICES, INC. •



MAIL SERVICE PRESCRIPTION DRUG PROGRAM

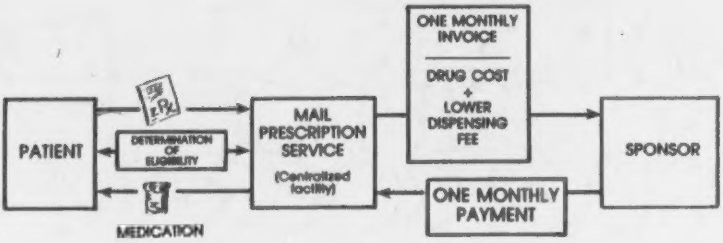
NRx

A Cost Containment Program For Prescription Drug Benefits

NRx NATIONAL PHARMACIES, Inc.

INTRODUCTION

OVERVIEW OF MAIL PRESCRIPTION SERVICE


ONE MONTHLY INVOICE
DRUG COST + LOWER DISPENSING FEE
PATIENT
Rx
DETERMINATION OF ELIGIBILITY
MAIL PRESCRIPTION SERVICE
(Centralized facility)
SPONSOR
MEDICATION
ONE MONTHLY PAYMENT

- Providing a prescription benefit and encouraging employees to use appropriate medication not only relieves the employee of a financial burden, but can have a value far beyond its immediate visible cost to the sponsor — that is *to reduce absenteeism and/or hospitalization.* Hospitalization and physician fees represent over 80% of health care costs, so money spent for prescription benefits is money well spent. National Pharmacies offers effective prescription programs while at the same time controlling their costs.

- National Pharmacies has been a pioneer in the development of mail service prescription drug programs. National, a division of a public company, has been providing this more efficient delivery systems for prescription drugs for over 15 years, long before health care cost containment became popular.

- National Pharmacies is the largest mail service prescription drug company. Its size, dedication to service and sophistication in data processing operations make it the best possible company to provide clients with a mail service prescription drug program.

- National Pharmacies' mail service prescription drug program can provide significant cost savings while improving the level of benefit to employees.

WHAT ARE THE ADVANTAGES OF A MAIL SERVICE PRESCRIPTION DRUG PROGRAM?

A CHANGE IN CONCEPT

- The program is a more efficient delivery system which entitles employees to defined prescribed drugs in specific quantities rather than to reimbursement for prescription drug claims.

MOST COST-EFFICIENT DISPENSING SYSTEM

- Economies of scale result in a cost-efficient delivery system with a lower cost per prescription dispensed than the typical retail pharmacy:
    - Pharmacists only engage in dispensing prescriptions.
    - Volume purchasing of drug inventory results in the lowest possible cost.
    - Dispensing from a central location avoids costly transfer of inventory from warehouses to retail locations.
    - Sophisticated counting equipment and computer systems maximize the efficiency and accuracy of the dispensing process.
    - The most modern materials handling and mailing equipment speeds prescription drugs on their way to the patient.

COST CONTAINMENT THROUGH SIGNIFICANT COST REDUCTIONS

- Avoids retail drugstore prices.
- Substantially reduces administrative costs.
- Provides greater substitution of lower cost generic drugs.
- Eliminates abuse since employee utilization is closely monitored in one central dispensing location while eligibility and covered drugs are electronically controlled.
- A custom-designed program controlled at a centralized location with detailed usage reports for benefits monitoring and planning.
- Convenience for the employee and retiree by using a mail service for delivery to the home of up to a 90-day supply of maintenance drugs, rather than purchasing every 30 days at a drugstore.
- Reduces the number of professional fees by not limiting prescriptions to a 30-day supply as retail programs do.

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EXAMPLE COMPARISON OF PROGRAM COSTS

	TYPICAL MAJOR MEDICAL		PLASTIC CARD		MAIL SERVICE	
	30 DAY SUPPLY	90 DAY SUPPLY	30 DAY SUPPLY	90 DAY SUPPLY	30 DAY SUPPLY	90 DAY SUPPLY
Average Price of Prescription Drug	$14.30*	$42.90*	$10.00	$30.00	$10.00	$30.00
Typical Dispensing Fee	(included in	retail price)	2.75	8.25	1.25	1.25
Typical Administrative Fee	.75	.75	.75	2.25	—	—
Postage	—	—	—	—	.50	.50
Total Price of One Prescription	$15.05	$43.65	$13.50	$40.50	$11.75	$31.75

*Assumes only a 30% markup — many stores have higher markups.

- One of the major cost savings of the mail service program is illustrated above. Typical major medical and plastic card programs impose a limit of 30 days of medication. Each time a prescription is filled there is another dispensing and administrative fee.

  The mail service program will provide clients' employees with a cost-efficient system that can be based on a 90-day supply. This plan eliminates repetitive administrative and dispensing fees. The savings on the average price of a prescription for 90 days is $11.90 per prescription or 37% for the typical major medical program and $8.75 per prescription or 22% for the plastic card program in the above example.

- The benefits of a 90-day supply are further demonstrated by the fact that about 70% of prescriptions are for maintenance drugs or long-term medication.

  In addition, the need for maintenance drugs increases with age. Both the client and employees will be able to take advantage of continued savings and convenient home delivery.

- The savings shown above do not include additional savings from greater generic drug substitution or elimination of abuse.

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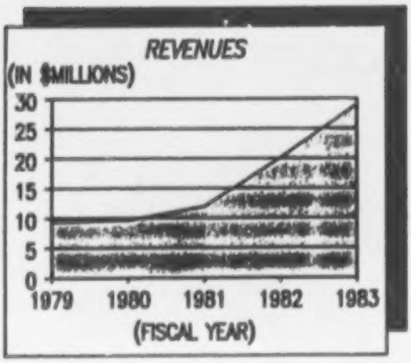
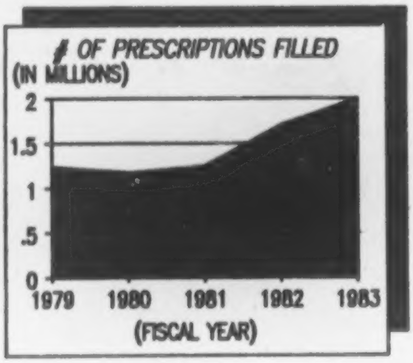
WHO IS NATIONAL PHARMACIES?





- Pioneered mail service prescription drug programs beginning in 1969 as a subsidiary of APL Corporation, a publicly owned company listed on the New York Stock Exchange. Current revenues and numbers of prescriptions dispensed for fiscal 1984 are at the rate of $38,000,000 and 2,300,000 respectively.
- Provided service initially for the Health Service Plan of the International Ladies Garment Workers Union and other unions; then since 1980, added five separate Ohio Public Retirement Systems as well as numerous other corporate customers.
- Current customers include more than 200 corporations, unions, groups and associations, health and welfare trusts and public employee systems.
- Acquired by Porex Technologies Corp. in 1983 and is now the dominant business of this public company.

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EXECUTIVE TEAM

- Managed by experienced executives with a broad background in home health care, cost containment and pharmaceuticals:

MARTIN J. WYGOD Chairman and Chief Executive Officer	• Over 10 years of experience as founder and Chief Executive Officer of major public companies in home health care and medical cost containment businesses.
LEONARD SCHATZBERG Senior Officer	• Twenty years of experience in drug wholesaling and 10 years of experience in mail service prescription drugs.
FREDRICK KLEIN Senior Officer	• Registered pharmacist and founder of National Pharmacies with 25 years of experience in mail service prescription drugs.
JAMES V. MANNING Chief Financial Officer	• Formerly a partner in a "Big Eight" public accounting firm and chief financial officer of a major home health care company.

PARTIAL LIST OF CUSTOMERS

- CORPORATIONS:
  - AM International
  - BF Goodrich
  - Church of Life Insurance Corporation
  - General Motors
  - Household Merchandising
  - Huffy Corporation
  - Metropolitan Life Insurance Company
  - PAID Prescriptions
  - Weyerhaeuser
- RETIREMENT SYSTEMS:
  - State Teachers Retirement Systems of Ohio
  - Public Employee Retirement System of Ohio
  - School Employee Retirement System of Ohio
  - Police and Firemen's Disability and Pension Fund
- UNIONS:
  - International Ladies Garment Workers
  - Oil Chemical and Atomic Workers
  - Carpenters Health and Welfare Fund of Philadelphia
  - United Auto Workers
  - United Transportation Workers Union
- ASSOCIATIONS:
  - National Council of Senior Citizens
  - Retired Officers Associations
  - Veterans of Foreign Wars

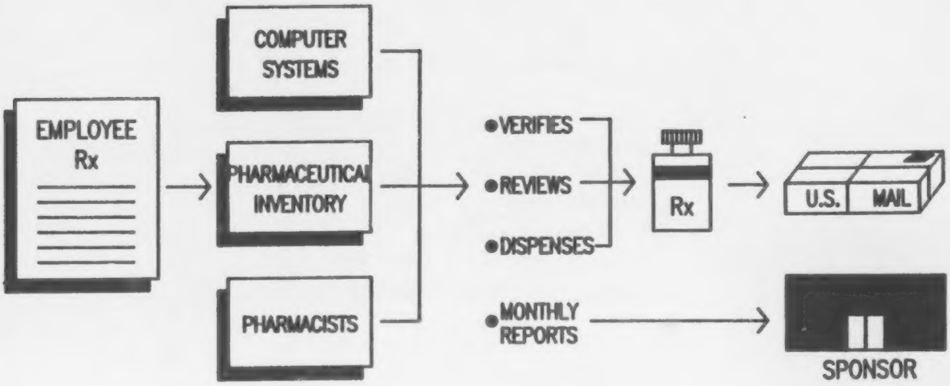
MAIL SERVICE PRESCRIPTION DRUG DISPENSING OPERATION

- Mail service pharmaceutical dispensing operations are conducted from a major automated facility in Elmwood Park, New Jersey and two smaller facilities in Los Angeles and San Diego, California.
- An additional major "state-of-the-art" dispensing operation will begin from a fourth facility in Columbus, Ohio in early 1984.

Over 8,000 new prescriptions and prescription refills are dispensed daily by qualified, professional pharmacists.

Customer service personnel and pharmacists are available to make and receive WATS line calls for direct communication with doctors and clients' employees and retirees when necessary.

MAIL SERVICE PRESCRIPTION DRUG DISPENSING OPERATION


EMPLOYEE Rx
COMPUTER SYSTEMS
PHARMACEUTICAL INVENTORY
PHARMACISTS
●VERIFIES
●REVIEWS
●DISPENSES
Rx
U.S. MAIL
●MONTHLY REPORTS
SPONSOR

- Registered pharmacists conduct the above simplified mail service process which has many built-in controls, reviews and verifications to insure an accurate and efficient dispensing system.
- A complete on-line data processing system is used to:
  - Maintain records of all prescriptions filled.
  - Check eligibility of employees and their dependents.
  - Provide individual profiles of drug usage for review by pharmacists.
  - Conduct verifications and checks for error avoidance, drug abuse and incompatibility of drug usage.
  - Determine whether or not prescriptions are in accordance with client plan characteristics.
  - Provide reports on prescriptions filled to client.
- Pharmaceutical inventories turnover in excess of 18 times a year, ensuring the freshness and potency dosage of each drug. Only FDA approved drugs are dispensed.

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- Quality control measures insure the accuracy of the prescription filled.
    - The prescription is initially reviewed by a pharmacist.
    - A second pharmacist compares the prescription against the patient profile.
    - A third pharmacist checks the computerized label against the original prescription.
    - A fourth pharmacist fills the prescription.
    - A final pharmacist makes a quality control check of the prescription and medication prior to mailing.
- Patient package inserts (PPI's), which are information leaflets describing the proper use and important characteristics of the medication, are mailed to employees and retirees with their medication.
- Client representatives are welcome for visual inspection of our dispensing facility and system at any time.

QUESTIONS YOU MAY HAVE ABOUT NATIONAL PHARMACIES, INC.

QUESTION: What about emergency medication?

The employee or retiree obtains emergency medication locally using existing major medical or plastic card programs.

QUESTION: How long does it take for a prescription to be filled?

Forty-eight hours from the receipt of the prescription until mailed, first class, back to the employee or retiree.

QUESTION: What items are covered by a mail service plan?

Drugs that require a doctor's prescription and that are specified by the client's plan.

QUESTION: What are the safeguards which the mail service program provides the employee or retiree?

A pharmacist checks the prescription against the Patient Profile Card which lists allergies, drug sensitivities, chronic diseases and previously ordered prescriptions. Should there be a possibility of drug interaction or other adverse reaction, the pharmacist will contact the physician directly.

QUESTION: Is the pharmacist/employee contact missed?

No. The pharmacist's review under the mail service program is more extensive and complete as the prescription is reviewed against the employee profile. In addition, a leaflet is sent to the employee with information on drug usage and characteristics.

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WHAT ARE NATIONAL PHARMACIES' COMPETITIVE ADVANTAGES?

- **Size** — Approximately $38,000,000 in revenues and the world's largest mail service prescription drug company servicing large employee-based corporations and unions.
- **Service** — Fifteen years of high quality and accurate performance for custom-designed programs.
- **Sophistication** — Efficient, computer-driven system provides quick and accurate response and turnaround.
- **Track Record** — Stability and reliability of a publicly owned company with a strong balance sheet.
- **Management**— Continuity of professional managers with an excess of 10 years of experience in mail service prescription drug programs, medical cost containment and home health care.
- **Capacity** — Four facilities provide capacity for growth and good geographic coverage to meet the needs of our clients.

HCS HEALTH CARE SERVICES®
"Preferred Provider℠"

MAIL SERVICE MAINTENANCE DRUG PLANS

HCS HEALTH CARE SERVICES®

"Preferred Provider^{SM}"

Health Care Services Inc., is one of the largest central dispensing pharmacies in the U.S. HCS is a recognized leader nationwide in mail-service maintenance edication programs. Our modern computer- d headquarters are located in suburban iladelphia.

HCS has effectively reduced costs associated ith maintenance drugs for major companies, alth plans, union and employee groups.

HCS has developed the **Preferred rovider^{SM}** — Maintenance Drug Plan concept.

The **Preferred Provider^{SM}** Plan is more ficient than most programs. It maintains rict controls on dispensing of drugs and rovides increased savings to both you and e participant.

COST CONTAINMENT WITH QUALITY CONTROL

HCS can reduce costs associated with maintenance drugs by as much as 30% while improving the quality of a drug program. This is accomplished through automation and computerization.

HCS has established thorough auditing procedures focusing on:

- Participant Eligibility
- Drug Eligibility
- Drug Interactions
- Drug Allergies
- Duplicate Prescriptions
- Early Refills

—all of which contribute to improved quality control and a reduction in the misuse or abuse of the drug plan.

Legal generic drug substitution is emphasized with up to a 65% savings possible each time a substitution is made.

There are no start-up costs required by either you or the participant.

MANAGEMENT INFORMATION

HCS provides detailed management reports such as:

- Drug Utilization
- Patient Utilization
- Generic Utilization
- Cost Savings

These reports allow you to monitor both utilization and savings.

OVERVIEW

Health Care Services, Inc. has been an innovator in mail-service prescription drug plans for over 15 years. HCS had the foresight to develop an entirely new concept in reducing and improving health care costs and services. With its modern, state-of-the-art computerized facility located in Bala Cynwyd, PA (a suburb of Philadelphia), it is one of the largest and most sophisticated pharmaceutical operations in the United States.

Health Care Services is a leader in cost-containment programs including quality generic substitution programs. Our management team has over 50 years of combined cost-containment experience. HCS employs a staff of over 150 employees including 40 U. S. registered pharmacists. Currently, we serve over a million participants across the country.

Health Care Services' "Preferred Provider"^{sm} Mail Service Maintenance Drug Program can save employees and employers 20-30% of their costs associated with maintenance medications. It has recently been documented that over 70% of prescription drugs purchased and 80% of all prescription claims filed under major medical programs are maintenance medications.

Health Care Services has built its reputation through providing prescription maintenance drug medications at substantially reduced prices. HCS provides drug programs for many of the top Fortune 500 companies, life insurance firms, medical plans, and 2 of the 3 largest unions in America.

What's most impressive about Health Care Services, though, is not merely its size, volume of business or prestige. Rather, it is the fact that HCS has been able to incorporate old-fashioned thoroughness and service into its highly efficient prescription-filling procedures.

COST-CONTAINMENT

Health Care Services is able to reduce costs associated with maintenance medications in the following areas:

1) MEDICATION PRICES ARE BASED ON AWP.

Health Care Services' drug prices are based on the Average Wholesale Price (AWP) instead of retail prices. AWP refers to the most recently reported Average Wholesale Price as reported by Red Book, Blue Book, or other national pharmaceutical reporting services. There are dramatic differences between the retail price of a medication and the AWP.

2) VOLUME DISCOUNTS

Health Care Services offers volume discounts off of the AWP price based on the size of a group.

3) GENERIC SUBSTITUTION

Whenever permitted by law, Health Care Services will use an approved generic substitution. Each time a generic medication is substituted, there is up to a 70% savings realized.

4) LOWER DISPENSING FEES

Health Care Services' dispensing fees average less than 50% of retail dispensing fees. The larger the client, the lower the dispensing fee.

4) LOWER ADMINISTRATIVE COSTS

Health Care Services eliminates claims processing and reduces the number of prescription refills. Both reduce administrative costs.

5) REDUCTION IN MISUSE AND ABUSE OF DRUGS

Health Care Services performs pre-filling and drug interaction audits including eligibility verification. This prevents misuse and abuse of the plan eliminating unnecessary cost to the plan sponsor.

QUALITY & SERVICE

Computerized eligibility allows the checking of each prescription in advance of filling, not after the fact, as is the case with other prescription plans. Health Care Services' computerized drug interaction system combined with the drug allergy module is one of the most sophisticated in the country. The system is designed to immediately ascertain drug interactions between 2 or more drugs that have been prescribed by the same physician or different physicians.

Each prescription is screened by at least 3 registered pharmacists. Should any question or problem arise concerning a prescription, a pharmacist will contact the participants' physician directly to ensure accuracy.

As this strict screening and inspection procedure indicates, Health Care Services is extremely quality-conscious. We even take extra steps to ensure quality drugs are used. Whenever a generic medication is used, the participant can be assured that it is equal to its brand-name counterpart in every way except price. It will have the same active ingredients, is manufactured in the same way, and has the same action in the body as the brand-name drug.

HCS is meeting the prescription requirements of many groups across the country through greatly reduced prices and quality customer service. Toll-free lines are provided to our professional Customer Service Department. Licensed pharmacists are readily available to handle all customer or physician inquiries. Health Care Services, Inc. is dedicated to providing the highest quality service at a cost savings to our customers.

ADVANTAGES OF HEALTH CARE SERVICES' "PREFERRED PROVIDER"^{sm} MAINTENANCE DRUG PLAN

. . . TO EMPLOYER

- Immediate and ongoing cost savings
- Simple installation
- Flexible plan design
- Integrates with any program covering prescription drugs
- May be implemented on a voluntary basis

. . . TO EMPLOYEE

- Saves on out-of-pocket expenses
- Easy to use and understand
- Prompt efficient handling of prescription orders
- Convenient home delivery via first class mail or UPS
- Guaranteed quality medications
- Toll-free telephone number to Customer Services for fast professional answers to questions

SAVINGS THROUGH GENERIC USAGE
BRAND NAME VERSUS GENERIC

(Quantity of 100)

As of January 1, 1985

BRAND NAME	AWP	GENERIC EQUIVALENT	AWP
Hydrodiuril 50 mg.	$ 9.29	HCTZ 50 mg.	$ 1.94
Zyloprim 30 mg.	29.90	Allopurinol 300 mg.	13.20
Isordil 10 mg. tab	9.17	Isosorbide 10 mg. tab.	2.40
Hygroton 50 mg.	23.93	Chlorthalidone 50 mg.	5.63
Hydrodiuril 25 mg.	5.86	HCTZ 25 mg.	1.52
Aldactazide	23.75	Spironolactone w/HCTZ	7.45
Quinora 200 mg.	9.11	Quinidine 200 mg.	6.00
Zyloprim 100 mg.	10.92	Allopurinol 100 mg.	6.98
Meticorten 5 mg.	9.17	Prednisone 5 mg.	2.93
Apresoline 25 mg.	11.27	Hydralazine 25 mg.	2.79
Isordil 5 mg. oral	7.61	Isosorbide 5 mg. oral	1.90
Isordil 20 mg.	14.36	Isosorbide 20 mg.	2.95
Librium 10 mg.	18.19	Chlordiazepoxide 10 mg.	2.40
Orinase 500 mg.	17.49	Tolbutamine 500 mg.	4.95
Apresoline 50 mg.	16.81	Hydralazine 50 mg.	3.84
	$216.83		$66.88
Average	14.45	Average	4.46

Generic equivalent = 69% Savings

One of the surest ways to reduce prescription drug cost is to increase the ratio of generic drugs dispensed vs. brand name drugs. On the average there is a 69% savings when a generic drug is dispensed rather than a brand name drug.

HCS' generic dispensing ratio is over 20%. The general consensus is that that nation-wide generic dispensing ratio is between 5% and 8%, or 1/3 of HCS' ratio. As a result of a higher dispensing ratio of generic drugs, the average wholesale price of all drugs dispensed through HCS is 8% to 10% lower than the national average.

HCS is dedicated to appropriate generic drug dispensing. We believe in, emphasize, and practice, legal generic substitution.

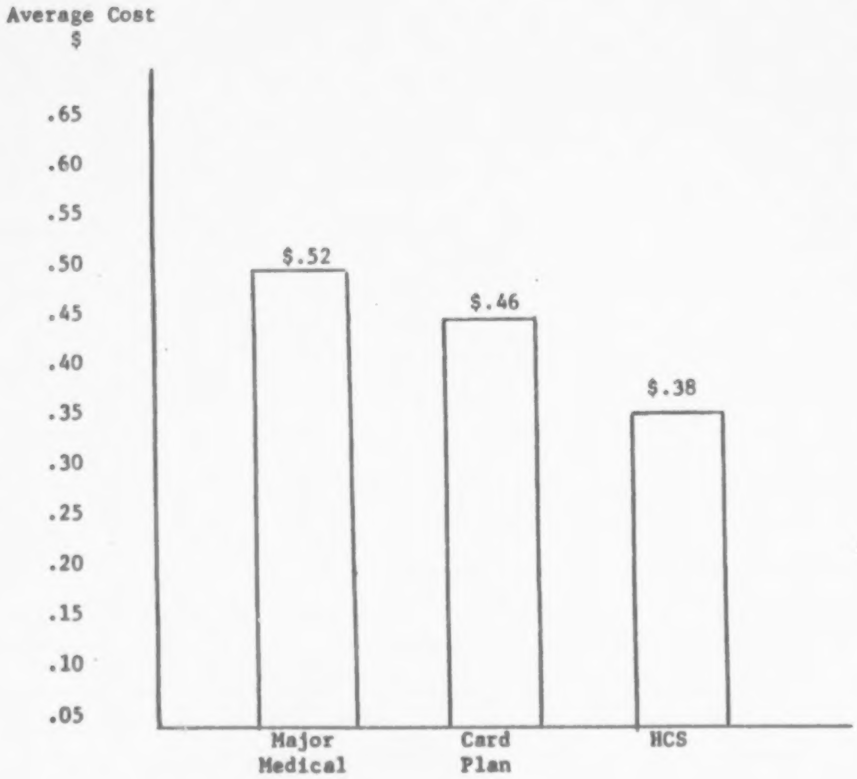
DRUG PLAN COST COMPARISON

AVERAGE DAILY COST

FOR

A MAINTENANCE MEDICATION Rx

(Includes administration costs)

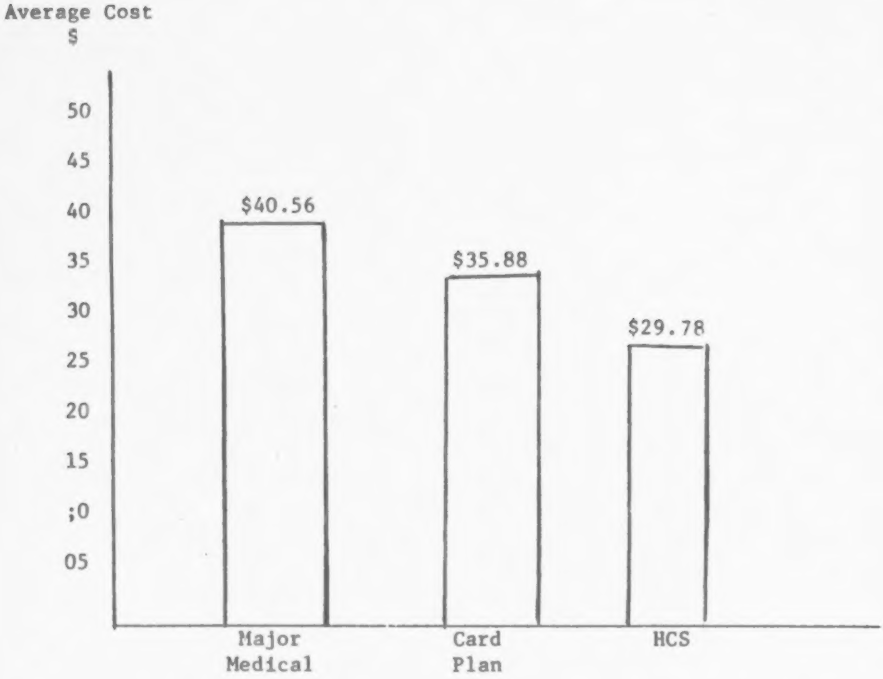


Average Retail Mark-Up over AWP	30%
Average Major Medical Administrative Cost	4%
Average Card Plan Dispensing Fee	$3.00/Rx
Average Card Plan Administrative Fee	.65/Rx
Average HCS Dispensing Fee	$1.25 *

* HCS fee includes postage & handling expenses

DRUG PLAN COST COMPARISON
78 DAY SUPPLY (Average Mail Service Supply)
For
A MAINTENANCE MEDICATION Rx

(Includes administration costs)



Average Retail Mark-Up over AWP	30%
Average Major Medical Administrative Cost	4%
Average Card Plan Dispensing Fee	$3.00/Rx
Average Card Plan Administrative Fee	.65/Rx
Average HCS Dispensing Fee	$1.25 *

*HCS fee includes postage & handling expenses

DRUG PLAN SAVING COMPARISON

78 DAY SUPPLY (AVERAGE MAIL SERVICE SUPPLY)

MAJOR MEDICAL		CARD PLAN	
Rx Cost	$40.56	Rx Cost	$35.88
Employee Co-Pay (20%)	8.11	Employee Co-Pay	6.00
Cost to Plan	$32.45	Cost to Plan	$29.88

HEALTH CARE SERVICES

Rx Cost	$29.78
Employee Co-Pay	- 3.00
Cost to Plan	$26.78

SAVINGS SUMMARY

	HCS vs. Major Medical		HCS vs. Card Plan	
Savings to Plan per HCS Rx	$ 5.67	17%	$ 3.10	10%
Savings to Employee per HCS Rx	5.11	63%	3.00	50%
Total Savings per HCS Rx	$10.78	27%	$ 6.10	17%

Savings for a 10,000 employee/member group with a major medical plan could be as high as $425,000 per year and as high as $300,000 per year if offered with a prescription card plan. (Card plan savings are lower because of the lower savings per Rx and also because lower utilization of a mail service plan is experienced when it is offered with a card plan.)

HEALTH CARE SERVICES, INC.

PARTIAL CLIENT LIST

- Aetna Life & Casualty Co.
- Alcan Aluminum Corporation
- American Express Co.
- Armstrong Rubber Company
- Atlantic Electric
- Carlisle Tire & Rubber Co.
- Conrail
- Dana Corporation
- Deseret Mutual Benefit Association
- Ex-Cell-O Corporation
- Ford Motor Company
- Good Year Tire & Rubber Company
- Health Group International
- Health Maintenance Network
- Hygrade Food Products Corporation
- International Ladies Garment Workers Union
- International Playtex, Inc.
- J. I. Case Co.
- James Benefits
- Johnson Controls
- Massachusetts Mutual Life Insurance Company
- Metropolitan Life Insurance Company
- Morrell & Company
- Motorola, Inc.
- N L Industries
- New York State Electric & Gas Corporation
- Provident Indemnity Life Insurance Company
- Reliance Electric Company
- Wilson Foods Corporation
- Wisconsin Education Association

CONVENIENCE

The **Preferred Provider**^{SM} Plan is ideal for persons needing medications on a continual basis for conditions such as arthritis, diabetes, emotional distress, heart disorders, etc.

All medications are delivered directly to the participant's home.

Toll-free telephone service provides direct contact with our Customer Services Department.

FLEXIBILITY AND FREEDOM OF CHOICE

HCS's Preferred Provider^{SM} Maintenance Drug Plan can be tailored to meet your specific needs and those of the participants. Drugs presently "covered" by an existing program, current plan exclusions and the deductible paid by the participant may remain the same if desired, or may be altered to better meet the needs of all concerned.

The participant and his family may obtain their maintenance medications through Health Care Services Inc., or continue to use your current drug benefit plan.

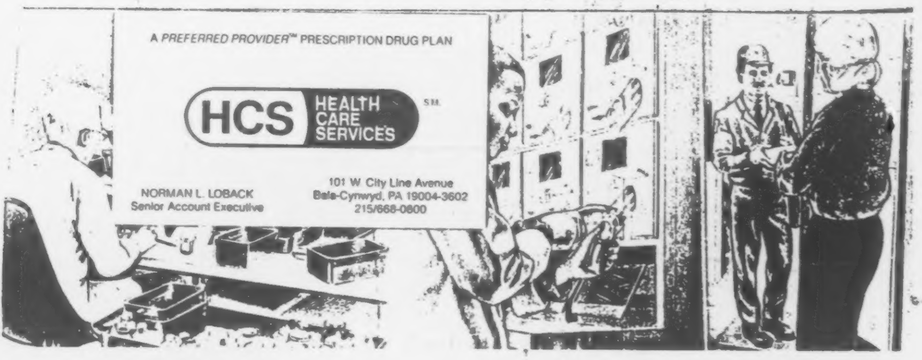
SATISFACTION

Each prescription filled by Health Care Services Inc. is reviewed, filled and inspected by U.S. traine and registered pharmacists.

Prescriptions are filled within 24-48 hours after receipt by HCS.

Registered pharmacists are always availabl to answer questions that may arise. They can be contacted through the Customer Service Department using our toll-free number.

HCS guarantees that every prescription fille meets the highest pharmaceutical standards o quality, safety and effectiveness.



A *PREFERRED PROVIDER*™ PRESCRIPTION DRUG PLAN

HCS HEALTH CARE SERVICES SM

NORMAN L. LOBACK
Senior Account Executive

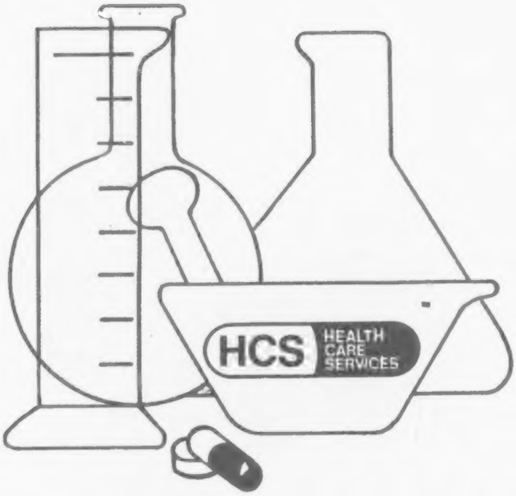
101 W. City Line Avenue
Bala-Cynwyd, PA 19004-3602
215/668-0800

For more information on Health Care Services Inc.'s Preferred Provider^{SM} Mail Service Maintenance Drug Plan, contact:

Health Care Services Inc.
Marketing Department
101 W. City Line Avenue
Bala-Cynwyd, PA 19004-3601
(215) 668-0800

HEALTH CARE SERVICES
101 WEST

HEALTH CARE SERVICES Inc.


HCS
HEALTH
CARE
SERVICES

101 W. City Line Ave. - P.O. Box 80 - Bala-Cynwyd, Pa. 19004
215 - 668-0800

HCS HEALTH CARE SERVICES S.M. *Preferred Provider* Prescription Drug Plans

As an Employee Benefits Administrator, you are most likely interested in cost containment possibilities for your company. Health Care Services can help you dramatically in this area.

HCS is a company located in Bala-Cynwyd, Pennsylvania, a suburb of Philadelphia. We have been in business over fifteen years. Our main product line is a "Preferred Provider"sm Mail-Service Maintenance Drug Plan. We are dedicated to providing high quality service at a cost savings to our customers. We have designed programs specifically for employers with a major medical drug plan or a prescription card drug plan. Retirees and Medicare people are especially benefited by our programs. HCS has programs with several insurance carriers, third-party administrators, associations, unions and employers.

We may be able to work together to provide savings to both you and your employees. Please review the enclosed information, and we will contact you in the near future.

101 W. City Line Avenue Bala-Cynwyd, PA 19004-3602
(215) 668-0800

HEALTH CARE SERVICES, INC.

Health Care Services is a large, central-dispensing mail-order pharmacy located in suburban Philadelphia. A recognized leader in cost containment and mail-service prescription medication programs, HCS has built its reputation by providing prescription maintenance drug medications at substantially reduced prices and through quality customer service. We are meeting the prescription requirements of many groups across the country... including Fortune 500 companies (see client list attached).

The operation is completely computerized for prompt and efficient handling of all orders... with the ability to perform pre-filling audits on patient eligibility, drug interactions, drug allergies, duplicate prescriptions and detection of early refills. Registered pharmacists prepare and supervise filling of all orders. Toll-free telephone lines to our customer service department are provided. Licensed pharmacists are available to handle customer or physician inquiries. Our Preferred Provider ^{sm} mail service maintenance drug plan can save 20% to 30% on costs associated with maintenance drug medications.

ADVANTAGES OF HEALTH CARE SERVICES' "PREFERRED PROVIDER"^{sm} MAINTENANCE DRUG PLAN

. . . TO EMPLOYER

- Flexible plan design
- Integrates with any program covering prescription drugs
- Simple installation
- Can be installed on a total employee group basis or by selected employee groups within the total group
- May be implemented on a voluntary basis
- Immediate and ongoing cost savings

. . . TO EMPLOYEE

- Saves on out-of-pocket expenses
- Easy to use and understand
- Prompt efficient handling of prescription orders
- Convenient home delivery via first class mail or UPS
- Guaranteed that every prescription meets the highest pharmaceutical standards of quality, safety and effectiveness
- Toll-free telephone number to Customer Services for fast professional answers to questions

HEALTH CARE SERVICES, INC.
Illustrative Comparison
Major Medical Plan
vs.
HCS "Preferred Provider"^{sm} Maintenance Drug Plan

Assumptions:

A.	Persons using maintenance medications usually have sufficient other medical expenses to satisfy their major medical plan deductible	
B.	Number of employees eligible to participate	10,000
C.	Annual maintenance medical at retail (AWP + 30% mark up)	$1,684,375
D.	Number of maintenance medication Rx's at retail	96,250
E.	Average-days supply of retail maintenance medication Rx	35
F.	Average cost of maintenance medication Rx at retail	$17.50
G.	Major Madical plan employee co-pay	20%
H.	Major Medical plan administrative rate	4%
I.	Type of HCS plan used in comparison	90-day
J.	HCS average-days supply per Rx	78
K.	Number of HCS Rx's required	43,120
L.	Average cost of HCS Rx at AWP	$30.00
M.	HCS dispensing fee per Rx	$.70
N.	HCS employee co-pay	$4.00
O.	HCS volume discount	5%

PROJECTED COSTS

Major Medical:

1.	Cost of maintenance medications submitted	$1,684,375
2.	Employee co-pay (G x 1)	$ 336,875
3.	Net cost of medications to plan (1 - 2)	$1,347,500
4.	Administrative charges (H x 3)	$. 53,900
5.	Total cost to employer (3 + 4)	$1,401,400
6.	Total cost to employee (2)	$ 336,875
7.	Total cost to employer and employee (5 + 6)	$1,738,275

HCS "PREFERRED PROVIDER"^{sm} 90-day Plan:

1a.	Total cost of medications at AWP (K x L)	$1,293,600
2a.	Less volume discount (O x 1a)	$ 64,680
3a.	Net cost of medications to plan (1a - 2a)	$1,228,920
4a.	Employee co-pay (N x K)	$ 172,480
5a.	HCS dispensing fee charges (M x K)	$ 30,184
6a.	Total HCS costs to employer (3a - 4a + 5a)	$1,086,624
7a.	Admin. fee paid to Major Med Plan administrator (H x 6a)	$ 43,465
8a.	Total cost to employer (6a + 7a)	$1,130,089
9a.	Total cost to employee (4a)	$ 172,480
10a.	Total cost to employer and employee (8a + 9a)	$1,302,569

SAVING SUMMARY

HCS Savings to employer (5 - 8a)	$271,311 (19%)
HCS Savings to employee (6 - 9a)	$164,395 (49%)
HCS Total Savings	$435,706 (25%)

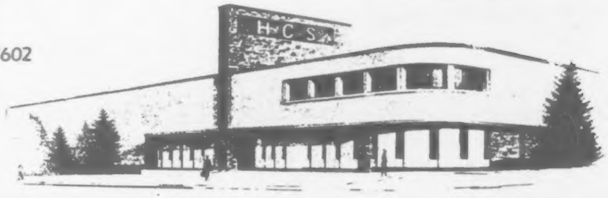
Savings per HCS Rx filled $10.10

To find out more about Health Care Services' **Preferred Provider℠** Prescription Drug Plan and how it can help you and your employees,

write or call:

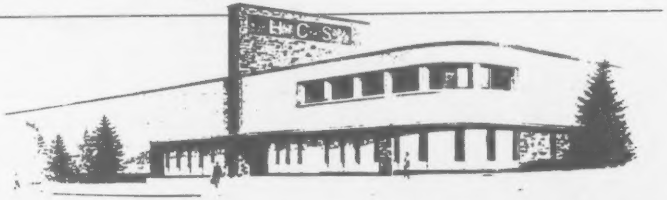
Marketing Department
Health Care Services, Inc.
101 W. City Line Avenue
Bala Cynwyd, PA 19004-3602
(215) 668-0800

HCS HEALTH CARE SERVICES℠



New Headquarters
on Philadelphia's
"Main Line"

You and your employees can reduce prescription drug costs.



Health Care Services, Inc., A **Preferred Provider℠** Maintenance Drug Plan

Health Care Services' **Preferred Provider℠** Maintenance Drug Plan means—

Cost Containment that Works—

- Health Care Services can reduce your costs associated with maintenance drugs 15–20%.
- Health Care Services can reduce misuse and abuse of drugs.
- Health Care Services reduces administration costs while providing detailed reports that allow the employer to monitor utilization and savings.
- Health Care Services can be implemented with no start-up costs to the employer or the employee.

Convenience—

- Health Care Services delivers non-emergency drugs right to the employee's home.
- Health Care Services is ideal for persons needing regular medication for conditions such as high blood pressure, arthritis, diabetes, asthma, and others.
- Health Care Services provides toll-free numbers direct to our Customer Service Department.

Freedom of Choice—

- The employee or dependents may use Health Care Services as an option to an existing drug benefit plan or continue using the current plan—whichever best meets their individual needs.

Flexibility—

- Health Care Services' **Preferred Provider℠** Maintenance Drug Plan can be tailored to meet your and your employees' specific needs.

Customer Satisfaction—

- All prescriptions filled by Health Care Services are reviewed at least three times by U.S. trained and licensed pharmacists.
- Prescriptions are filled within 24–48 hours after receipt by Health Care Services.
- Licensed pharmacists are available at all times through the Customer Service Dept. to answer questions.
- If questions arise concerning medications, our licensed pharmacists contact the participant's physician directly.

Please present this portion to your physician.

TO YOUR PHYSICIAN!

Dear Doctor:

Your patient is enrolled in a third-party, maintenance prescription drug program which permits up to a 180 days supply of medication when so prescribed by you. Refills, when authorized by you, are permitted to a maximum of one year except where prohibited by law.

The Plan Sponsor requests your cooperation in prescribing medication to the Plan's 180 days maximum when medically feasible or appropraite. This request is not intended to compromise your judgment, nor is it a request to order medication that will not be used.

Example: *If the patient takes one daily, please write the exact quantity of 180 with one refill . . . Two daily, prescribe 360, etc. You must specify the exact quantity you wish. When applicable, please include your DEA number and either use a form showing your name clearly or print your name. Please include daily directions, proper strengths, and the exact number of refills you wish.*

THANK YOU FOR YOUR COOPERATION.
HEALTH CARE SERVICES, INC.™

Profile Information – *continued* Please complete the following section for all eligible family members.

Name ______________ Relationship ______ Date of Birth ______ Sex ______
Name ______________ Relationship ______ Date of Birth ______ Sex ______
Name ______________ Relationship ______ Date of Birth ______ Sex ______
Name ______________ Relationship ______ Date of Birth ______ Sex ______
Name ______________ Relationship ______ Date of Birth ______ Sex ______

Number of Prescriptions Enclosed ______________
Prescriptions are for: ☐ Cardholder ☐ Spruse ☐ Sons ______________ (names)
☐ Daughters ______________ (names) ☐ Other ______________ (name)

Note: No deductible is required for prescription ordered from Health Care Services, Inc.

I CERTIFY THAT THE INFORMATION ON THIS FORM IS CORRECT, AND AUTHORIZE RELEASE OF ALL INFORMATION TO PLAN SPONSOR, ADMINISTRATOR, OR UNDERWRITER.

Date ______________ Cardholder's Signature ______________

HYGRADE FOOD PRODUCTS CORP.

26877 Northwest Highway, Southfield, Michigan 48034

Is Eliminating Your Copayment for Prescription Drugs

This benefit is provided thru:

HCS HEALTH CARE SERVICES

A Preferred Provider Prescription Drug Plan.

HEALTH CARE SERVICES, INC., 101 W. City Line Avenue, Bala-Cynwyd, PA 19004-3602

CONVENIENT HOME DELIVERY
OBTAIN UP TO A SIX MONTH SUPPLY

A Preferred Provider Prescription Drug Plan is an excellent way to obtain non-emergency drugs through the mail. It is ideally suited for persons needing reguler medication for conditions such as high blood pressure, arthritis, diabetes or asthma.

Will I need to get new prescriptions?
To begin receiving medications through this plan, you will need to get new prescriptions from your doctor.

HCS HEALTH CARE SERVICES ™

A Preferred Provider Prescription Drug Plan

If I am not enrolled, how do I enroll?
When you wish to place your first prescription order:

- Complete the Profile Information form.
- Enclose original Prescription(s), from your Physician
- Mail both to Health Care Services, Inc.

When assistance is needed concerning your prescription order you may call ***toll free.***

Customer Service:

1-800-432-5801	1-800-222-7711
Outside Pennsylvania	In Pennsylvania

DETACH HERE

PROFILE INFORMATION

Health Care Services, Inc.
101 W. City Line Ave., P.O. Box 100
Bala-Cynwyd, PA 19004-3602

Please complete this form and return it to Health Care Services, Inc. in the enclosed pre-addressed envelope. Be sure to sign the form and enclose your prescription(s).

PCS ID Card Number (as it appears on your plastic PCS ID card.) ☐☐☐☐-☐☐☐☐-☐☐☐-☐☐-☐☐☐☐

Group Name HYGRADE FOOD PRODUCTS CORP.

Cardholder's Name (please print) ____________ First MI Last Sex: M ☐ F ☐

Address ____________ Street City State Zip

Home Phone No. ____________ Area Code Work Phone No. ____________ Area Code Date of Birth ____________

DETACH HERE

Dear Physician,

If you have any questions concerning this plan,

please call TOLL FREE

HCS HEALTH CARE SERVICES ™

1-800-432-5801	1-800-222-7711
Outside Pennsylvania	In Pennsylvania

A Preferred Provider Prescription Drug Plan.

Hours: 9 to 5 Eastern Time, Monday thru Friday

PLEASE PRESENT THIS PORTION

TO YOUR PHYSICIAN

Dear Doctor:

Your patient is enrolled in a maintenance prescription drug program which permits up to a 90-day supply of medication when so prescribed by you. Refills, when authorized by you, are permitted to a maximum of one year except where prohibited by law.

> **Example:** Please write your prescription and specify the exact quantity (1 daily × 90 days = 90; 2 daily × 90 days = 180, etc.). Please include daily directions, proper strength, the exact number of refills and the generic name of the medication. Also, when applicable, include your DEA number. Use a pre-printed form, or clearly print your name and phone number on your form.

BenePlan Strategies, this employee's Plan Administrator, request that you prescribe medication for the Plan's 90-day maximum when medically feasible and appropriate. They also ask that you allow the GENERIC substitute whenever lawful and safe. These requests are not intended to compromise your judgement, nor to order medications that will not be used.

If you have any questions concerning this program, please contact Health Care Services, Inc., Professional Relations Dept., toll-free at 1-800-432-3841 (Outside Pennsylvania) or 1-800-222-7711 (In Pennsylvania). 9 am — 8 pm Eastern Time.

THANK YOU FOR YOUR COOPERATION
HEALTH CARE SERVICES, INC.

DETACH HERE DETACH HERE

HCS HEALTH CARE SERVICES SM

HEALTH CARE SERVICES
101 W. City Line Avenue
P.O. Box 100
Bala-Cynwyd, PA 19004-3602

PROFILE AND DRUG ALLERGY INFORMATION

Please complete this form (both sides) and return it to Health Care Services, Inc. in the enclosed pre-addressed envelope. Be sure to sign the form and enclose your prescription(s) and $4.00 for each prescription. If you or your eligible family members have any drug allergies, please list the drug allergies under the appropriate name.

Employee's Social Security Number

☐ ☐ ☐ - ☐ ☐ - ☐ ☐ ☐ ☐

GROUP NAME ______ BENEPLAN STRATEGIES

Employee's Name ____________________ SEX: M ☐ F ☐

List Drug Allergies ____________________

Address ____________________ Street City State Zip

Home Phone Number ______ Area Code Work Phone Number ______ Area Code Date of Birth ______

Doctor's Name ____________________ Telephone No. ______ Area Code

DETACH HERE DETACH HERE

QUESTIONS AND ANSWERS ABOUT THE PLAN

Q. HOW DO I SAVE MONEY?

A. If you or a covered family member are presently taking medication on a regular basis (maintenance medication), you can now order up to a 90-day supply from Health Care Services, Inc., and pay only $4.00 for each prescription.

Q. WHAT IS THE DIFFERENCE BETWEEN GENERIC AND BRAND NAME DRUGS?

A. The generic name of a drug is its official chemical name. All drugs have a generic name. The brand name is the trade name under which the drug is advertised and sold. By law, generic and brand name drugs must meet the same standards for safety, purity, strength and effectiveness. When your physician prescribes generically, it permits a pharmacist to dispense a generic drug. This saves both you and your Plan money. So, ask your physician to prescribe generic drugs whenever possible.

Q. IS IT SAFE TO ORDER PRESCRIPTION MEDICATIONS THROUGH THE MAIL?

A. Yes. Every prescription is screened and filled by registered pharmacists, then inspected by another registered pharmacist to insure accuracy in quantity and potency. HCS guarantees that every prescription shipped to you meets the highest pharmaceutical standards of quality, safety, and effectiveness.

Q. WHAT ABOUT EMERGENCY SITUATIONS?

A. Obviously, there will be many times when you need a prescription immediately. On these occasions, we recommend that you have your prescription filled at a local pharmacy, using the same procedure as before.

HOW TO USE THIS PROGRAM

1. Ask your physician to prescribe a 90-day supply of needed medications. To insure prompt processing, make sure the physician's name, the patient's name, and the exact daily dosage are clearly indicated.

2. Complete the attached profile information form, making certain you indicate your social security number. (This form is only required with your first order.)

3. Use the self-addressed return envelope enclosed, or a regular envelope. Send the completed profile information form, your original prescriptions and co-payment to Health Care Services, Inc. (HCS), 101 West City Line Avenue, Post Office Box 100, Bala-Cynwyd, Pennsylvania, 19004-3602.

4. HCS will process your order and return your prescriptions to you along with re-order instructions for future prescriptions or refills. All orders will be sent via first-class mail or UPS.

5. If you need help or have any questions, contact HCS Customer Service. Call TOLL FREE 1-800-432-5841; in Pennsylvania 1-800-222-7711 Monday through Friday 9 AM to 8 PM Eastern Time.

HCS HEALTH CARE SERVICES S.M.

HEALTH CARE SERVICES
101 W. City Line Avenue
P.O. Box 100
Bala-Cynwyd, PA 19004-3602

PROFILE INFORMATION — *Continued* *Please complete the following section for all eligible family members.*

Name ____________ Relationship ____________ Date of Birth ____________ Sex ______
List Drug Allergies ____
Name ____________ Relationship ____________ Date of Birth ____________ Sex ______
List Drug Allergies ____
Name ____________ Relationship ____________ Date of Birth ____________ Sex ______
List Drug Allergies ____
Name ____________ Relationship ____________ Date of Birth ____________ Sex ______
List Drug Allergies ____
Name ____________ Relationship ____________ Date of Birth ____________ Sex ______
List Drug Allergies ____

I HEREBY CERTIFY THAT THE INFORMATION ON THIS FORM IS CORRECT.

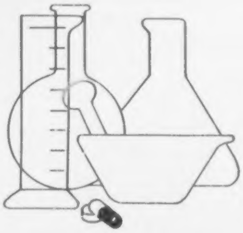
DATE ____________ EMPLOYEE'S/RETIREE'S SIGNATURE ________________________
Number of Prescriptions Enclosed with this profile ____________
NOTE: Deductible amount ($4.00) as required by your Plan ____________ × number of prescriptions ____________ = $ ____________ amount enclosed*

*Please make check or money order payable to Health Care Services, Inc.

BenePlan Strategies

HCS HEALTH CARE SERVICES S.M.

A Mail Service Prescription Program That Can Help Save You Money



Easy and convenient to use. This new program is ideal if you or a family member are taking medication on a regular basis.

SEE DETAILS INSIDE...

HEALTH CARE SERVICES, INC. 101 W. City Line Avenue, Bala-Cynwyd, PA 19004-3602

PARTIAL CUSTOMER LIST

Acme-Cleveland Corporation
Alcan Aluminum Corporation
Amalgamated Transit Workers, Local 726
American Community Mutual Insurance
American Sterilizer Company
Armstrong Rubber Company
Blue Cross/Blue Shield of Oregon
Budd Company
Carlisle Tire & Rubber Company
J. I. Case Company
Chicago District Council of Carpenters
Communications Workers of America, Local 1180
Dana Corporation
Deseret Mutual Benefit Association
Ex-Cell-O
Ford Motor Company
George A. Hormel & Company
Goodyear Atomic Corporation
Goodyear Tire & Rubber Company
Health Net of Southern California
Health Service Plan of Pennsylvania
Hygrade Food Products Corporation
International Brotherhood of Electrical Workers
International Ladies' Garment Workers Union
James Benefits
John Morell & Company
Massachusetts Mutual Life Insurance Company
Metropolitan Life Insurance Company
New England Health
New York State Gas and Electric Corporation
Philadelphia Federation of Teachers
Philadelphia Firefighters Association
Price Brothers Company
Reliance Electric Company
City and County of San Francisco
Swift Independent Packing Company
United Association (Pipefitters) Local 198
White Motor Company
Wilson Foods Corporation
Wisconsin Education Association Insurance Trust

DRESSER INDUSTRIES DRESSER

Mail Order Drug Plan

a convenient plan designed to save you money and time.

WHAT IS THE DIFFERENCE BETWEEN GENERIC AND BRAND NAME DRUGS?

The generic name of a drug is its chemical name. The brand name is the trade name under which the drug is advertised and sold. By law, generic and brand name drugs must meet the same standards for safety, purity, strength and effectiveness. When you or your doctor authorize generic substitution, it permits the Pharmacy to dispense a generic drug. Unless your physician indicates otherwise, National will dispense a generic equivalent when available and permissable under the law. This saves your plan money. So whenever possible, ask your doctor to prescribe generic drugs.

HELPFUL HINTS

To insure prompt processing of your order, check your prescriptions before you leave your doctor's office to make sure that:

- The doctor's name is legible.
- The exact daily dosage is indicated.
- The exact strength is indicated.
- The exact quantity is indicated.
- The full first and last name of the patient for whom the medication was prescribed is legible.

Although NATIONAL normally ships your prescription to you within 48 hours of receipt, please allow 14 days for delivery from the date you mail your prescription order. All orders are sent via First Class Mail or UPS, but allowing ample time will help you avoid the chance of running out of medication.

●

This program is serviced by

National Rx Services, Inc.
P.O. Box 16500
Columbus, Ohio 43216-6500

If you need help or have any questions, contact National's Customer Service Department, Monday through Friday, from 9:00 A.M. to 5:00 P.M. eastern time.

Toll Free Numbers:

In Ohio: 1-800-533-3578
Outside of Ohio: 1-800-221-0222
[Alternate Number: 1-614-228-2941]

© National Rx Services, Inc. 1984

COMPLETE and MAIL WITH FIRST ORDER

If an eligible dependent in your family has any allergies, any chronic diseases or is sensitive to any drug or drugs, please list below. If there are no allergies, chronic diseases or sensitivities, please check "none" and sign.

NAME ____________ RELATIONSHIP ____________ DATE OF BIRTH ____________ SEX ______
DESCRIBE CONDITION ________________________________

NAME ____________ RELATIONSHIP ____________ DATE OF BIRTH ____________ SEX ______
DESCRIBE CONDITION ________________________________

NAME ____________ RELATIONSHIP ____________ DATE OF BIRTH ____________ SEX ______
DESCRIBE CONDITION ________________________________

NAME ____________ RELATIONSHIP ____________ DATE OF BIRTH ____________ SEX ______
DESCRIBE CONDITION ________________________________

☐ NONE EMPLOYEE'S SIGNATURE ________________

WHAT IS THE MAIL ORDER DRUG PLAN?

The Mail Order Drug Plan is an expansion of your current prescription drug benefit program. It is ideal for those of you who take prescription medication on an on-going basis because you can now enjoy several important advantages:

- **Immediate savings:** You pay only $3.00 per prescription for up to a 90 day supply of medication!
- **No claim forms** to file.
- **No waiting** for reimbursement.
- **Convenience** of home delivery, postage paid.
- **Security** of receiving larger quantities of medication at one time (see "HOW CAN I RECEIVE A 90 DAY SUPPLY OF MEDICATION?").
- **Toll free** customer service number.

WHAT IS COVERED?

Prescription medications as presently covered by your Medical Benefits Plan.

WHO IS ELIGIBLE?

Non-union salaried and hourly employees, retirees, and their eligible dependents who are presently covered by Dresser Industries' Group Medical Benefits Plan.

IS IT SAFE TO ORDER PRESCRIPTION DRUGS THROUGH THE MAIL?

Yes, absolutely. National Rx Services, Inc. has been filling prescriptions through mail-service for many years. National Rx Services, Inc. guarantees that every prescription will be screened and filled by a registered pharmacist and be accurate in quantity and potency. National Rx Services, Inc. also guarantees that every health product shipped to you meets the highest pharmaceutical standards of quality, safety and effectiveness.

HOW WILL MY ORDER BE HANDLED?

When you order by mail, your prescription is reviewed by a pharmacist, checked against your patient profile, dispensed and verified by National's quality control department before it is mailed to you.

HOW DO I USE THIS PROGRAM?

1. Ask your physician to prescribe needed medications for up to a 90-day supply plus refills. If you are presently taking medication, ask your doctor for a new prescription.
2. Complete the attached Patient Profile Questionnaire with your first order only. Be sure to answer all the questions, and make certain you include your Social Security Number on the form.
3. Send the completed Patient Profile Questionnaire, your original prescription(s), and a $3.00 co-payment for each prescription to National Rx Services, Inc. using the enclosed reply envelope.
4. National Rx Services, Inc. will process your order and return your medications to you via First Class Mail or UPS, along with re-order instructions for future prescriptions and/or refills. Please allow 14 days for delivery.

HOW DO I ORDER REFILLS?

With your original prescription medication, you will receive a notice showing the number of times it may be refilled. Simply enclose this refill notice with your $3.00 co-payment for each prescription and mail to National in the pre-addressed order envelope (which has been provided). To avoid the risk of running out, order your refills two weeks before you need them.

WHAT ABOUT EMERGENCY SITUATIONS?

Obviously, there will be times when you need a prescription immediately. On these occasions, you should have your prescription filled at a local pharmacy. Payment for such a prescription will be handled under your present Medical Benefits Plan.

HOW CAN I RECEIVE A 90 DAY SUPPLY OF MEDICATION?

Your doctor must prescribe a 90 day supply for you to receive that quantity. The law requires that pharmacies dispense the exact quantity prescribed by the physician. If your doctor authorizes refills, they can only be dispensed when your initial order has nearly expired, so be sure to ask your doctor to prescribe a 90 day supply, plus refills, whenever appropriate.

DETACH ALONG DOTTED LINE

PATIENT PROFILE QUESTIONNAIRE

D R I

COMPLETE and MAIL WITH FIRST ORDER

NATIONAL Rx SERVICES, INC. • P.O. BOX 16500, COLUMBUS, OHIO 43216-6500

IMPORTANT: If you have any allergies, chronic diseases or are sensitive to any drug(s), please describe below. If there are no allergies, chronic diseases or drug sensitivities, please check "none" and sign.

PLEASE PRINT OR TYPE

COMPANY NAME: DRESSER INDUSTRIES, INC. Social Security Number

EMPLOYEE NAME ______ ☐☐☐-☐☐-☐☐☐☐

ADDRESS ______ CITY ______

STATE ______ ZIP ______ Daytime Telephone (____) ______

DATE OF BIRTH ______ SEX ______

DESCRIBE CONDITION ______

☐ NONE

THE STAMP OF POSTMASTERS EXCELLENCE

POSTMASTERS pbp BENEFIT PLANS

Mail Service Prescription Drug Program

a convenient plan designed to save you money and time.

WHAT IS THE DIFFERENCE BETWEEN GENERIC AND BRAND NAME DRUGS?

The generic name of a drug is its chemical name The brand name is the trade name under which the drug is advertised and sold By law, generic and brand name drugs must meet the same standards for safety, purity, strength and effectiveness When your doctor prescribes generically or authorizes generic substitution it permits the Pharmacy to dispense a generic drug This saves both you and your Plan money So whenever possible, ask your doctor to prescribe generic drugs

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HELPFUL HINTS

To insure prompt processing of your order, check your prescriptions before you leave your doctor's office to make sure that

- The doctor's name is legible
- The exact daily dosage is indicated
- The exact strength is indicated
- The exact quantity is indicated
- The full first and last name of the patient for whom the medication was prescribed is legible

Although NATIONAL normally ships your prescription to you within 48 hours of receipt, please allow 14 days for delivery from the date you mail your prescription order All orders are sent via First Class Mail or UPS but allowing ample time will help you avoid the chance of running out of medication

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This program is serviced by
NATIONAL PHARMACIES, INC
P.O. BOX 1000
ELMWOOD PARK, N.J. 07407

If you need help or have any questions, contact National's Customer Service Department, Monday through Friday, from 9:00 A.M. to 5:00 P.M. eastern time

NATIONAL PHARMACIES, INC.
CUSTOMER SERVICE DEPARTMENT
TOLL FREE NUMBERS
Outside New Jersey: 1-800-631-7780
In New Jersey: 1-800-562-6923
[Alternate Number: 201-791-8200]

DETACH ALONG DOTTED LINE

COMPLETE and MAIL WITH FIRST ORDER

If an eligible dependent in your family has any allergies, any chronic diseases or is sensitive to any drug or drugs, please list below. If there are no allergics, chronic diseases or sensitivities, please check "none" and sign.

NAME ____________ RELATIONSHIP ____________ DATE OF BIRTH ____________ SEX ______
DESCRIBE CONDITION ______________________________

NAME ____________ RELATIONSHIP ____________ DATE OF BIRTH ____________ SEX ______
DESCRIBE CONDITION ______________________________

NAME ____________ RELATIONSHIP ____________ DATE OF BIRTH ____________ SEX ______
DESCRIBE CONDITION ______________________________

NAME ____________ RELATIONSHIP ____________ DATE OF BIRTH ____________ SEX ______
DESCRIBE CONDITION ______________________________

☐ NONE MEMBER'S SIGNATURE ______________________________

WHAT IS THE MAIL SERVICE PRESCRIPTION DRUG PROGRAM?

The Mail Service Prescription Drug Program is an improvement and expansion of your current prescription drug benefit program. It is ideal for those of you who take prescription medications on an on-going basis because it offers several advantages:

- **Low costs:** You pay only $3.00 per prescription
- **No claim forms** to file
- **No waiting** for reimbursement
- **Convenience** of home delivery
- **Larger Quantities:** you can now receive up to a 90 day supply of medication at one time (see "HOW CAN I RECEIVE A 90 DAY SUPPLY OF MEDICATION?")
- **Toll free** customer service number.

WHAT IS COVERED?

Prescription medications currently covered by your Health Program.

WHO IS ELIGIBLE?

Member and dependents properly enrolled in Postmasters Benefit Plan Low Option.

IS IT SAFE TO ORDER PRESCRIPTION DRUGS THROUGH THE MAIL?

Yes, absolutely. National Pharmacies, Inc. has been filling prescriptions through mail-service for many years. National Pharmacies, Inc. guarantees that every prescription will be screened and filled by a registered pharmacist and be accurate in quantity and potency. National Pharmacies, Inc. also guarantees that every health product shipped to you meets the highest pharmaceutical standards of quality, safety and effectiveness.

HOW WILL MY ORDER BE HANDLED?

When you order by mail, your prescription is reviewed, checked against your patient profile, dispensed and verified by National's quality control department before it is mailed to you.

HOW DO I USE THIS PROGRAM?

1. Ask your physician to prescribe needed medications for up to a 90-day supply plus refills. If you are presently taking medication, ask your doctor for a new prescription.
2. Complete the attached Patient Profile Questionnaire with your first order only. Be sure to answer all the questions, and make certain you include your Social Security Number on the form.
3. Send the completed profile card, your original prescription(s), and a $3.00 payment for each prescription to National Pharmacies Inc. using the enclosed reply envelope.
4. National Pharmacies Inc. will process your order and return your medications to you via First Class Mail or UPS, along with instructions for future refills.

HOW DO I ORDER REFILLS?

With your original prescription medication, you will receive a notice showing the number of times it may be refilled. Simply enclose this refill notice with your $3.00 payment for each prescription and mail to National in the pre-addressed order envelope (which has been provided). To avoid the risk of running out, order your refills two weeks before you need them.

WHAT ABOUT EMERGENCY SITUATIONS?

Obviously, there will be times when you need a prescription immediately. On these occasions, you should have your prescription filled at a local pharmacy and submitted for reimbursement under your Health Insurance Plan subject to the annual deductible.

HOW CAN I RECEIVE A 90 DAY SUPPLY OF MEDICATION?

Your doctor must prescribe a 90 day supply for you to receive that quantity. The law requires that pharmacies dispense the exact quantity prescribed by the physician. If your doctor authorizes refills, they can only be dispensed when your initial order has nearly expired, so be sure to ask your doctor to prescribe a 90 day supply, plus refills, whenever appropriate.

DETACH ALONG DOTTED LINE

PATIENT PROFILE QUESTIONNAIRE

NATIONAL PHARMACIES, INC. • P.O. BOX 1000, ELMWOOD PARK, N.J. 07407

COMPLETE and MAIL WITH FIRST ORDER

IMPORTANT: If you have any allergies, chronic diseases or are sensitive to any drug(s), please describe below. If there are no allergies, chronic diseases or drug sensitivities, please check "none" and sign. The law requires that we maintain a Patient Profile.

PLEASE PRINT OR TYPE

GROUP NAME ____ POSTMASTERS BENEFIT PLAN

Member's Social Security Number ☐☐☐-☐☐-☐☐☐☐ GROUP - P B P

MEMBER NAME ____________

ADDRESS ____________ CITY ____________

STATE ______ ZIP ______ Daytime Telephone (____) ______

DATE OF BIRTH ______ SEX ______

DESCRIBE CONDITION ____________

☐ NONE

United States
Office of
Personnel Management
Washington, D.C. 20415

In Reply Refer To: Your Reference

March 3, 1987

Dear Carrier:

This is the annual call for proposed benefit and rate changes from plans participating in the Federal Employees Health Benefits Program. Specific instructions concerning information required to support requests for rate changes are enclosed.

In accordance with 5 CFR 890.203(b), requests for the contract term beginning January 1, 1988, must be received no later than May 31, 1987. We urge you to submit your request before the deadline. Requests for benefit changes submitted after the deadline will not be considered.

To assure a timely Open Season, we will begin negotiations as soon as possible. Immediately after we receive requests for benefit and rate changes, we will establish a negotiation schedule to ensure that all negotiations (benefits and rates) are completed not later than August 15, 1987.

Guidance on Benefit Changes

We anticipate that rapidly rising health care costs will exert an upward pressure on FEHB rates for 1988. Since the program is already costing the Government and FEHB enrollees more than $6 billion a year, we are very sensitive to further cost increases. We will, therefore, consider benefit change proposals only in the context of zero cost benefit tradeoffs.

We continue to believe that Federal employees are best served by benefit packages that are strong in the traditional areas of hospital, surgical, and medical benefits and that provide protection against significant and largely unforeseeable health care expenditures. We also continue to believe in the efficacy of enrollee cost-sharing to restrain unnecessary utilization. Guidance on specific benefit areas for the 1988 contract year follows:

Catastrophic Protection. A recent report of the U.S. General Accounting Office, which compared health insurance coverage for Federal and private sector employees, indicated that FEHB plan enrollees are more likely than private sector plan enrollees to have catastrophic protection. However, the report noted that private sector plan enrollees who are covered by catastrophic benefits generally have lower out-of--pocket limits than FEHB plan enrollees. With this in mind, we ask you to look at your catastrophic protection benefit in terms of its continued adequacy in 1988.

Mental Health and Substance Abuse. As we have indicated for the past several years, we will accept no reduction in the value of mental health benefits offered. We encourage modest improvements in this area and would be willing to consider them as an exception to the zero cost increase requirement stated above. While we realize you have had little opportunity to assess experience under the substance abuse benefits instituted last year, we will also consider modest enhancements in this area.

Dental Benefits. We will not consider increases in dental schedules for 1988 in fee-for-service plans or the addition of any dental procedures over your 1987 benefit package. We will accept new dental programs in prepaid plans only where they are an integral part of the community package and offered at the community rate.

Mail Order Prescription Drugs. Contrary to our earlier expectations, mail order prescription programs do not appear to reduce the total expenditures for drugs. Plans already offering such programs are encouraged to increase co-pays to make them cost neutral. Plans wishing to add mail order programs must design them on a zero cost increase basis.

Vision Benefits. Consistent with our emphasis on basic benefits and protecting against significant, unbudgetable expenses, we will not consider proposals to add vision care programs to fee-for-service plans. We will accept new vision programs in prepaid plans only where they are an integral part of the community package and offered at the community rate.

Other. Carrier response to last year's requests for benefits covering well baby and hospice care was so positive that we believe these areas are now reasonably well covered in most plans. We will, however, continue to accept proposals from plans still lacking this coverage or desiring modest enhancements on a cost neutral basis.

Cost Containment

While we continue to be interested in benefits design and benefits administration features that serve to restrain unnecessary utilization and encourage cost control, we must be satisfied that such features do, in fact, have the desired effect. We welcome proposals for such cost containment measures as pre-certification and concurrent review programs, pre-admission testing, second surgical opinions, designated outpatient surgical procedures, preferred provider arrangements and claims audits, if they are not already a part of your plan and can be supported by documentation of cost effectiveness.

Impact of Possible Medicare Changes

We are unable to assess at this time what, if any, impact proposed changes in the Medicare program may have on the FEHBP. As this issue becomes clear, additional guidance may be provided.

Brochure Printing Subcontracting

Again this year, we expect you to print your brochures. In accordance with the FARs, you should select your printing subcontractor on a competitive basis to the maximum practical extent consistent with the objectives and requirements of the contract.

Evaluation of Proposed Benefit Changes

All requests for benefit changes will be evaluated in the light of effective utilization and cost control and the economic and health needs of Federal enrollees. Efficiency of administration and the amount of premium needed to support present benefits and requested changes are also important considerations.

Requests for benefit changes must be precisely described and supported by your best estimate of their impact on premium rates. Only changes that are supported by actuarial justification will be considered. Proposed brochure language must also be submitted with requests for benefit changes, including language for a "How Benefits Change in 1988" page. Brochure language must describe benefits, exclusions, limitations, definitions and procedures accurately and clearly, and should be set forth in plain English. This is especially important, since we are continuing the brochure standardization process begun last year. We are clarifying and consolidating benefits, limitations and exclusions in selected plan brochures as well as making commonly used definitions uniform.

We know we can count on your favorable response to our request for no-cost benefit changes in 1988, just as you have cooperated on issues of significance to the FEHB Program in the past.

Disclosure Policy Under Freedom of Information Act

Any information included in your letter may be subject to public disclosure after negotiations with all carriers are completed and new contracts are announced. Please identify each item in your letter that you believe is exempt from disclosure under the Freedom of Information Act. Also, specify which exemption you believe applies to that item and give full justification for your belief that the exemption applies.

We will decide on disclosure only when a request for information is made. In making our decision, we will consider the justification for non-disclosure submitted with your letter. If we decide that any specific item of information that you believe is exempt is not exempt from disclosure, we will so inform you before it is disclosed.

Sincerely,

Carlos F. Esparza

Carlos F. Esparza
Assistant Director
for Insurance Programs

SEP 25 1987

CNE

James N. Gillman, Vice President
Federal Employee Program
Blue Cross and Blue Shield Association
1615 L Street, NW, Suite 800
Washington, D.C. 20036

Dear Mr. Gillman:

Recently the Senate Subcommittee on Government Efficiency, Federalism, and the District of Columbia held oversight hearings regarding the mail order prescription drug programs offered by carriers in the Federal Employees Health Benefits Program (FEHBP). During these hearings, several safety-related concerns were raised.

While OPM has no regulatory authority over carriers' provider arrangements (including agreements with mail order drug vendors), we are nonetheless interested in seeing that the medical services provided to FEHBP enrollees meet basic standards of safety and quality. Therefore, we request that you review your existing arrangements with mail order vendors to ensure that adequate quality control and safety systems are in place.

In addition, if you are recontracting your mail order drug service for 1988, we ask that you make extra efforts to see that the chosen firm(s) have in place appropriate procedures and standards to guarantee quality and safety.

If you become aware of any safety-related deficiencies in the mail order drug operations of the vendor with whom your plan has a contract, please immediately bring those deficiencies to my attention. Thank you for your assistance and cooperation in this matter.

Sincerely,

/s/ Jean M. Barber

Jean M. Barber
Associate Director
for Retirement and Insurance